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FALLING THROUGH THE CRACK: THE IMPACT OF DRUG-EXPOSED CHILDREN ON THE CHILD WELFARE SYSTEM

HEARING

BEFORE THE

SUBCOMMITTEE ON
CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

ON

EXAMINING THE IMPACT OF DRUG-EXPOSED CHILDREN ON THE WELFARE SYSTEM

MARCH 8, 1990

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CONTENTS

STATEMENTS

THURSDAY, MARCH 8, 1990

	Page
Kohl, Hon. Herbert, a U.S. Senator from Wisconsin	5
Prepared statement	7
Wilson, Hon. Pete, a U.S. Senator from California	9
Prepared statement	14
Kleber, Herbert, M.D., Deputy Director for Demand Reduction, Office of national Drug Control Policy, Executive Office of the President	18
Prepared statement	21
Mangano, Michael F., Deputy Inspector General for Evaluations and Inspections, Department of Health and Human Services; Dr. Ira J. Chasnoff, president, National Association for Perinatal Addiction Research and Education, Chicago, IL; and Dr. Amy B. Wheaton, commissioner, Department of Children and Youth Services, Hartford, CT	28
Prepared statements of:	
Mr. Mangano (with attachments)	31
Dr. Chasnoff	96
Dr. Wheaton	106
Coletti, Shirley D., president, Operation Par, St. Petersburg, FL; Kathleen M. West, MPH, director, program development, perinatal substance abuse program, Martin Luther King, Jr. General Hospital, Los Angeles, CA; Joe Kroll, executive director, North American Council of Adoptable Children, St. Paul, MN; and Donna Tice, program participant, Operation Par, St. Petersburg, FL	148
Prepared statements of:	
Ms. Coletti	151
Ms. West	169
Mr. Kroll	187
United Way of New York City, prepared statement	206
Project Return Foundation, Inc., prepared statement	209

ADDITIONAL MATERIAL

Articles, publications, etc.:	
Drawing the Line on Prenatal Rights, from the Los Angeles Times, May 14, 1989, by Alan Dershowitz	17
Highlights and questions from the working paper on Chemical Dependency, from the Child Welfare League of America, Inc.	125
Questions and answers:	
Responses of Michael Mangano to questions asked by Committee	70

FALLING THROUGH THE CRACK: THE IMPACT OF DRUG-EXPOSED CHILDREN ON THE CHILD WELFARE SYSTEM

THURSDAY, MARCH 8, 1990

U.S. SENATE,
SUBCOMMITTEE ON CHILDREN, FAMILY,
DRUGS, AND ALCOHOLISM,
OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:30 p.m., in room SD-430, Dirksen Senate Office Building, Senator Christopher J. Dodd (chairman of the subcommittee) presiding.

Present: Senators Dodd, Pell, Adams, and Coats.

OPENING STATEMENT OF SENATOR DODD

Senator DODD. The subcommittee will come to order.

I would first of all like to welcome all of you in the room today to the Subcommittee on Children, Family, Drugs, and Alcoholism's hearing on "Falling Through the Crack: The Impact of Drug-Exposed Children on the Child Welfare System."

A month ago I visited an intensive care unit at a New York City hospital filled with infants exposed to drugs before birth. Their eventual homes were as uncertain as their lives were tenuous. The crack epidemic has been with us for several years now. Many drug-exposed infants are now toddlers and preschoolers. It is time to look at the emerging evidence and ask what the future holds for children like those in that neonatal unit and who will care for them. It is certainly time, long overdue, to craft a comprehensive response to their problems.

The immediate effects of cocaine exposure on infants are well documented: higher rates of sudden infant death syndrome, low birthweights, and other physical problems, irritability, difficulty relating to caregivers.

Of course, not all drug-exposed infants will show these symptoms. Research is beginning to emerge, however, that suggests subtle but troubling longer-term effects.

In addition, professionals who work with children are seeing alarming signals. For example, a pediatrician in a child development center notices an unusual number of children with autistic-type symptoms. A Head Start teacher notices more children whose short attention spans and hyperactivity hinder them from fitting

into normal classroom situations. For these children and society, the future costs of perinatal exposures are staggering.

Today we will review for the first time a major Federal study that concludes that at least 100,000 babies each year are born addicted to cocaine. By the year 2000, there may be as many as four million cocaine-exposed children in this country.

For many of these children, early medical costs will continue throughout their lives. Many more will likely face difficulties as they enter preschool and elementary school. If developmental delays are not addressed, the problems and the costs snowball—for special education, school dropouts, and lost productivity. At a minimum, cocaine-exposed children will cost this Nation $100 billion in remedial, medical, and developmental costs over the next decade.

Many drug-exposed infants will not remain with their families. Recent estimates indicate that there was a 30 percent increase in the number of children in foster care between 1986 and 1989, and these children are streaming into foster care at a very young age.

We must be very careful about the care that we as a society give these children. In many cities, the pool of foster parents is strained to the limit. Foster parents receive little training and low compensation. Most alarming is the frequent mention of orphanages for infants and toddlers.

For some drug-exposed children, the goal of a permanent home is elusive at best. Reunifying addicted mothers and their children can be very tough. Women substance abusers need treatment oriented to their special problems and those of their children. Such treatment, however, is sadly lacking across this country. The consequence is a longer stay for children in foster care; in some cases, 3 or 4 years. The lack of drug treatment makes decisions about freeing the children for adoption, never easy, even more wrenching.

We do not have all the answers, obviously, about how to help drug-exposed infants. We do know that reaching their mothers early in pregnancy improves their chances dramatically. We know that there are model programs that treat mothers and children together with some success. The Odyssey House program in New York is one that comes to mind immediately, but I would point out to those of you here this morning that in the entire city of New York, Odyssey House has the only residential treatment program for mothers and children. That's only 25 beds for the entire city of New York for such treatment. And we know that if we wait for all the answers, many more cocaine-exposed children will be born before we respond to their plight.

I believe that we must act now on what we do know. We must respond to these vulnerable children and their families in a comprehensive way, one that recognizes substance abuse as one of the many problems facing these families. I believe we must reshape our child welfare system to better exemplify this concept, building a continuum of services for all families.

I have several principles that I hope will form the basis for a legislative response to this problem. First of all, I believe we need a national commitment to drug treatment on demand for all pregnant substance abusers and women with young children, including a full range of services for children of substance abusers.

Second, we must develop comprehensive approaches for serving these troubled families, parents and children together, through family resource and support programs and by strengthening child protective services' ability to respond to family problems.

Third, we must improve the availability and quality of foster care, including a commitment to healthy young children that they will not be placed in congregate care.

Finally, we must explore and clarify the difficult legal questions raised by perinatal substance abuse to help State and local programs and judiciaries balance the natural rights of parents with the rights of children to permanent, safe environments as early as possible.

I hope that the distinguished witnesses who are here this afternoon will offer their thoughts on how best to respond to these children and their families. It is not an easy task and it will not be accomplished overnight, but we must make a beginning.

I cannot erase from my mind the images of those tiny infants in the intensive care unit sustained only by tubes and respirators. We can do better for them and their mothers. We can make their future and ours as a society far brighter than was offered in that intensive care unit.

Now I turn to my colleague Senator Adams, and then we will be delighted to hear from our two colleagues Senator Wilson and Senator Kohl.

Senator Adams.

Senator ADAMS. Thank you, Mr. Chairman.

OPENING STATEMENT OF SENATOR ADAMS

I appreciate the Senators being with us this afternoon and the others.

Mr. Chairman, in recent months, this subcommittee has served as a forum for discussing the most tragic and frightening aspects of our national drug abuse problem: the use of cocaine, heroin, and other illegal drugs by pregnant women and women of childbearing age.

As with you, Mr. Chairman, my visits to the hospitals in my State confirm to me personally the horror of this problem and the tremendous difficulties of the boarder babies which we are now beginning to develop in our hospitals, babies that are boarded there because they have no place to go.

In struggling to understand the physical and psychological causes of drug addiction, no example more fully demonstrates the slavery of drug addiction than the pregnant addict. To learn that the craving for drugs can override even essential maternal concern for the well-being of an unborn child is a frightening and tragic phenomenon.

I am pleased to see that the Department of Health and Human Services has begun to quantify the problem of the so-called "crack baby" and to make policy recommendations for dealing with the problem at the Federal, State, and local level.

And yet, it still appears that the more we learn the less we know. The President's national drug abuse strategy estimates 100,000 cocaine-exposed babies are born each year. Experts tell us,

however, that between 30,000 and 375,000 babies have been affected by maternal drug abuse.

The future costs of dealing with these babies and their physical and social needs will be staggering. We must begin now to develop systems that will deal with these tragic outcomes and to reduce the numbers of pregnant women who use drugs in the future. A national drug effort that fails to confront this issue is doomed to failure.

In Seattle, Washington, pediatricians tell me that 20 percent of the women who deliver at our public hospitals are drug abusers. The term crack baby is really inadequate, Mr. Chairman, as a description. And I hope our witnesses today will further expand upon multiple drug use and the variety of drug use that leads to fetal compromise.

My State follows only Texas, California, and Oregon as a location for illegal drug labs—our Nation's next nightmare. And I want to be certain that everyone in this room today and everyone who hears my voice understands that this is the next nightmare, and it is with us now: a smokable type of methamphetamine known as "ice."

Last year alone, illegal drug labs were seized in the State of Washington, and there were 93 of them. But ironically, during the same year there were only 90 inpatient beds available for high-risk, low-income individuals with drug and alcohol problems. We had more labs than beds.

Mr. Chairman, a young woman from my State recently told the Seattle Times how she once used enough meth to stay awake for 27 days. Her health deteriorated. Her husband started forging checks to support their habits. And after a life spent in living hell, she is now in recovery, but the effect of her drug habit was devastating. She stated, "I lost my marriage, I lost my house, I lost my kids, I lost it all."

I hope we will get some advice today that will help the Congress understand the dimension of this problem and how we should respond to a generation of citizens yet unborn. They deserve to be planned into our national drug prevention strategy. And I want to emphasize that this is a multiple drug problem, and it is one that some of us that live in national cities where this has become a problem feel that we must have a Federal program to help our local programs which are being overrun.

Thank you very much, Mr. Chairman.

Senator DODD. Thank you, Senator Adams.

Senator Coats.

OPENING STATEMENT OF SENATOR COATS

Senator COATS. Mr. Chairman, this is the third hearing we have held on the various aspects of the effect of drugs, and I want to thank you for convening these hearings. The first one was held in Indiana last fall, which was a very important hearing, including our Nation's drug czar, and a field hearing in New York just a few months ago. And though these hearings were held in various parts of the country, including this one in Washington, it is clear that the problem and the effects are unfortunately the same every-

where we go. Rural and urban communities alike are feeling the results of the plague of drug abuse.

Through this hearing we will learn that substance abuse is not a victimless crime, that in fact it is a growing threat to the health and well-being of our most vulnerable citizens, our children. When a mother uses drugs, it's child abuse through the umbilical cord, and this type of abuse leaves its permanent imprint on the lives of a staggering number of drug-exposed infants.

Already, health care services are showing signs of major strain. Private clinics are closing, citing the high costs of treating crack babies and other cocaine-related health problems. Social services have been overrun with cases in which substance abuse is a major factor. In the Nation's capital, 90 percent of all cases in child protective services are substance abuse-related.

I spoke recently to a group in Indianapolis that has made a major multimillion-dollar commitment on a private basis to reach out to the homeless, and they have been overrun with drug-addicted individuals who they accept and treat and reach out for, but it has literally overwhelmed their ability to provide the kinds of services that they initially had intended to provide.

Drug abuse is not a crime that just affects the user, it is an enemy of nurture, it is an enemy of families, and it is an enemy of the helpless innocent.

Mr. Chairman, I want to State to those present here that it is my understanding that this evening the Child Welfare League of America will hold its annual meeting in honor of you and Senator Hatch for your work on behalf of children. I will be with Senator Warner tonight at an event the President is attending and won't be able to be there, but I want to congratulate you for this award and this recognition, which I think is well deserved, and thank you again for convening this hearing and for the work you do on behalf of children.

Senator DODD. Thank you very much, Senator Coats. I appreciate your kind remarks about this evening as well.

Senator Kohl, Senator Wilson, we welcome both of you here. It's a pleasure to have both of you before the committee. It is a long-standing interest I know both of you have had in this subject matter generally.

Senator DODD. Senator Kohl, we will start with you. Do you have a prepared statement?

STATEMENT OF HON. HERBERT KOHL, A U.S. SENATOR FROM THE STATE OF WISCONSIN

Senator KOHL. Thank you. Yes, Mr. Chairman. I would like to express my appreciation for the opportunity to be here before you today.

Many of the programs which help children and their families were developed in this very room, and these kids need our help again. I hope very much that we can respond.

Seven months ago Senator Wilson joined me at a Governmental Affairs hearing which I chaired on the issue of substance abuse by pregnant women. I wanted to see how we could improve the services we provide to these people. What I found was that we couldn't

improve them because we barely had them. We discovered that there just aren't residential drug treatment services available to women and their children.

In Wisconsin, META House is the only service around, and it can only serve 10 to 12 women with children a year. In various degrees, all of our States face the very same problem.

The chairman knows well of the fine work done by Crossroads in Connecticut. He also knows how much work they are unable to do. The story is the same all over America. Even when a woman seeks help for substance abuse, she can't get it. And getting it often means that she has to accept as a condition of treatment separation from her children. We are forcing her to make an impossible decision. We are forcing her to make "Sophie's Choice."

When we fail at prevention, when we fail at treatment—which is true today—we make it inevitable that the entire social welfare system will also fail. Look at the facts, Mr. Chairman. Child abuse reports are up 300 percent in five years in Wisconsin. Caseworkers are overloaded and burning out fast. Families are stressed. Children's courts are jammed. Foster parent demand is so great that in Milwaukee, as in many other cities across our Nation, there is talk of orphanages and a return to institutional care.

The child welfare system in our country is under siege. I hope that the report released by the Inspector General today will force us to confront both the costs of our mistakes and the challenges of reform.

In 1989 we spent $4 million to prevent substance abuse among women of childbearing years. But according to the IG's report there are now 100,000 cocaine babies. We are going to be forced to spend for these 100,000 babies $5 billion per year just for medical and foster care for their first five years of life.

As bad as that is, it says nothing about the costs throughout their lives, the problems that medical and foster care alone will never be able to solve.

But we do know how to solve some of these problems. We must emphasize prevention, not only through drug programs but through coordination of community-based services targeted at women and kids. We must alleviate the treatment crisis and remove barriers to care for women and their families. We must retool the child welfare system, arming it with more trained caseworkers, shoring up the foster care system, improving training, recruitment and salaries. We must prepare our schools and communities to cope with affected children and their families, strengthening special education, outreach, and early intervention opportunities.

And, Mr. Chairman, we must develop new and better ways to coordinate services. No single agency can meet the needs of these children and their families. Health care, social services, drug and alcohol treatment, and housing must be active partners on both the Federal and the local levels.

These steps, if taken, will respond to the crisis, but they will not resolve the causes of the crisis. If we are going to do more than slap a band-aid on open sores, we have to get to the root of this crisis.

Whether we are responding to drug abuse, child neglect, illiteracy, homelessness, school dropout rates, or teenage pregnancy, Mr. Chairman, they are increasingly manifestations of poverty in America.

It is not coincidental that child poverty rates have soared along with parental drug problems and child maltreatment. Between 1979 and 1987, the number of children living in poverty in Wisconsin jumped by 52 percent, and across the Nation today children make up 40 percent of all of those who are living in poverty. And this is the greatest injustice and challenge facing us as a Nation.

I am committed to working with you, Mr. Chairman, to address the crisis of substance abuse among pregnant women, of the child welfare system, and I urge this committee's continued action on behalf of all of America's children.

Thank you very much for this opportunity.

[The prepared statement of Senator Kohl follows:]

PREPARED STATEMENT OF SENATOR KOHL

Senator KOHL. Across the Nation, we are facing an emergency as powerful as hurricane Hugo or the San Francisco earthquake. Unlike these natural disasters, I am talking about an emergency with a very human face: Pregnant women addicted to drugs and alcohol. This public health emergency now threatens the well-being of hundreds of thousands of mothers and children. And it will overwhelm our hospitals, child welfare agencies, and schools unless we take immediate steps to address it.

Mr. Chairman, I commend you and your subcommittee for holding a hearing on this pressing issue. You have been a leading voice in Congress for a long time on the needs of children and families in this country. Due to your efforts, issues like child care are now at the forefront of public concern. So it is a privilege to be here with you today.

Last summer, I chaired a hearing before the Governmental Affairs Committee, looking at the need to coordinate prevention and treatment services for alcoholic and drug-dependent women. The statistics I heard then were staggering. I know that with childcare, Senator Dodd, you focused on availability, affordability, and quality. Well, with drug and alcohol treatment for pregnant women, there are so few programs you can't get beyond the issue of availability.

In Milwaukee, in my home State of Wisconsin, 500 pregnant women will need drug and alcohol treatment services this year. But there is only one residential drug treatment center for women and children in the entire State. And that center—META House—can serve only 10 to 12 women a year. Wisconsin is not unique. In Connecticut, I understand that only one center—Crossroad—allows women undergoing residential drug treatment to keep their children with them.

Like many other States, Wisconsin has also seen a dramatic rise in reports of child abuse and neglect linked to parental drug and alcohol problems. Overall reports in my State soared from about 10,000 in 1983 to some 31,000 in 1988. Forty-one percent of the affected children were under the age of 5. Child welfare workers cannot keep up with all these reports. And agency heads are having a hard time finding workers with any experience in substance abuse or family violence issues.

It is not coincidental that child poverty rates have soared in my State as well. Between 1979 and 1987, the number of children living in poverty increased by 52 percent. The problems of parental substance abuse, child maltreatment, and poverty are intimately connected, Mr. Chairman. And we cannot solve one or the other without addressing them all.

Without more centers like META House and Cross-Roads, women will have to choose between keeping their children or going into drug treatment. Without more prevention and treatment options, the child welfare system will remain under siege. Without more drug treatment slots, prenatal care and WIC providers will have no place to refer the addicted pregnant women they see. And without material and child health, drug and alcohol treatment, and child welfare agencies working together, thousands of women and children will continue to fall through the cracks.

The Inspector General's survey you will hear about this morning gives us a clear snapshot of these problems. It also focuses on short-term costs: To provide acute

care for the 9,000 "crack babies" identified in the survey costs half a billion dollars a year. If these are 100,000 such babies born a year—as suggested by Mr. Bennett—we will spend $5 billion for education, and social services necessary to prepare these children for school and help them graduate. When you multiply out those costs, the numbers go right off the charts.

Mr. Chairman, we know what must be done. We have to start emphasizing prevention. We need to reach out to women at risk: Those who have been the victims of family violence, who are homeless, who have few job skills and low self esteem. The Office for Substance Abuse Prevention (OSAP) is only funding a handful of prevention programs aimed at such women. And too few communities have had the time or funds to focus on prevention because they are struggling to provide treatment.

We have to take resounding steps to alleviate the treatment crisis. Even if we doubled the Senate authorization for OSAP treatment programs—making it $100 million—we would still only reach 17,000 pregnant women and only provide residential care for 6,000 of them. We can and must do better. And we must remove barriers to care for women. Only two drug treatment programs for pregnant women in the entire city of New York provide child care. That makes no sense.

We have to strengthen and retool a child welfare system that is on the verge of collapse. As the I-G will report, some workers have 125 child abuse cases to oversee. They don't have time to file their papers, let alone protect the children. We have to focus on shoring up the foster care system, given the dramatic jump in infants and preschoolers needing out-of-home care. And, we need to deal with training, recruitment and salary incentives given the staff turnover in most agencies.

We have to help prepared our schools and communities to cope with the affected children. We cannot afford to lose ground with special education initiatives now. They must be expanded and strengthened. And we have to increase outreach and early intervention opportunities for children and parents.

And, we must come up with new and better ways to coordinate services. No single agency can meet the needs of these children and their families. We need to use one-stop shopping to deliver essential health care, social services, drug and alcohol treatment, and housing assistance in a coordinated way that makes sense.

Finally, we must address poverty as an underlying cause of family stress and dysfunction. Although drug and alcohol problems have no economic boundaries, it should come as no surprise that poverty makes them much, much worse. Across the Nation, children now make up 40 percent of those living in poverty. In fact, we are the only industrialized Nation in which children are the poorest age group.

Mr. Chairman, I look forward to working closely with you to combat these problems. I've asked my staff to work on some proposals and hope we can work together to make some real difference for millions of children and their families.

In closing, this is an area in which we could learn from the Japanese. They were able to move their infant mortality ranking from 17th to 1st among industrialized nations. They did so by focusing on results. We need to do the same, Mr. Chairman. We should stop debating about the number of pregnant women who need drug and alcohol treatment, and start ensuring that their addiction rates go down. We should stop talking about the importance of education and start preparing our schools for the entrance of children adversely affected by maternal drug use. And we should start taking steps to ensure that children will no longer be the poorest age group in this country. That is no way to treat the next generation if we want to remain the strong, competitive Nation we have always been.

There is some good news here today. Unlike hurricanes or earthquakes, we now have advance warning of this disaster. We can take steps to prepare and focus efforts on prevention. I hope this hearing will signal a new focus on results.

Thank you.

Senator DODD. Thank you very much, Senator Kohl. I appreciate your involvement with these issues already in your statement today is reaffirmation of that commitment, and we look forward to working with you as well.

Pete, we welcome you to the committee. You have had a long-standing interest in this subject matter generally, and it is no surprise at all that you would be interested in the more specific subject here of the victims, the innocent victims of this problem. So we welcome you to the committee.

STATEMENT OF HON. PETE WILSON, A U.S. SENATOR FROM THE STATE OF CALIFORNIA

Senator WILSON. Thank you very much, Mr. Chairman. First of all, congratulations on your well-deserved award tonight.

Senator DODD. Thank you.

Senator WILSON. And thank you for holding this hearing.

As Senator Kohl has told you, last year he convened a hearing of the subcommittee actually of the Governmental Affairs Committee, and I think that it was the first time that in the Senate there had been witnesses focusing on this specific and this most tragic, to my way of thinking, most troubling aspect of drug use. But as he has pointed and as you have pointed out in your very eloquent opening statement, what we are concerned with here is not simply the problem of crack babies—and I think Senator Adams' comments were very much on point—we are concerned with substance abuse during pregnancy and its tragic effects upon the child who actually is delivered who is an innocently addicted newborn, whether that child is a victim of the fetal alcohol syndrome or a crack baby or, as Senator Adams has pointed out, the next generation of nightmare, to use his phrase, and I think it's not an exaggeration, that of the innocent newborn who will be the victim of his mother's abuse of ice, a smokable methamphetamine, though I am told that the potency of that is so enormous that there is a likelihood that many of the children will not survive to actually be delivered.

But, Mr. Chairman, as your statement indicated, this problem is an epidemic. That again is a word that is, I think, well advised. It is not exaggeration. We have had a number of statistics. Let me add some that I think make it clear that not only are we dealing with a clear and present danger but one that is very clearly growing, growing annually, and as has been pointed out, it is not purely the problem of the cities or the inner cities.

In Los Angeles County, according to a letter that I received from the young chief of obstetrics and gynecology at the Harbor UCLA Hospital, Dr. Fonakura. Dr. Fonakura wrote to me in a very eloquent letter that the problem was increasing at what she described as a logarithmic progression. And as evidence of that fact, she cited that in Los Angeles County in the year 1985 there had been something over 500 addicted newborns delivered, that in the next year the number exceeded 1,000, that in the following year it exceeded 1,500, that in the year following that it exceeded 2,500, and the prediction is that by 1993 the number will exceed 10,000.

In testimony, again either at the first of those meetings or at the second, we have heard from Governor Celeste of Ohio, and we heard testimony from Governor Martinez that his anticipation is that next year in Florida there will be 10,000 addicted newborns.

So we are looking at a phenomenon that is literally exploding before our eyes, and the costs are exploding as well.

There has been reference made to crack babies, to boarder babies, that being the euphemism for those abandoned because of the particularly insidious effect of crack, the destruction of the maternal instinct. They do number in the hundreds of thousands. The official estimate of the National Association of Perinatal Addiction Research and Education—I note that Dr. Chasnoff is on your list of

witnesses—is 375,000. From what I am hearing, I can't help but suspect that the number exceeds that.

But what is clear is that whatever the number is today, it is growing so rapidly that I doubt that we can keep count.

As your own experience has indicated, and that of Senator Adams in his home State of Washington, for any of us who have had the experience in Indiana or Wisconsin or California, walking through a neonatal intensive care unit and actually holding one of these pathetic infants born weeks premature, at a dangerously low birthweight so that you can literally hold the child in one hand, weighing two pounds, in some cases even less, these are truly pathetic infants, as you said, hooked up to life support systems with all kinds of tubes.

It is a truly pathetic situation from the moment that they enter the world, and the most experienced and caring of neonatal intensive care unit nurses have told me, as I am sure they have told you, there is almost no comforting these children for weeks, that it takes time as well as special efforts to withdraw them. That piercing cry they have is indicative of a condition that is almost beyond comforting.

Of course, that is only the beginning, literally. They literally face a life in many cases of diminished capacities, as you have indicated, Mr. Chairman, in your statement. It isn't guaranteed, but the probability is enormously high that they will suffer some truly serious diminution of their capacity, ranging from mental retardation to physical deformity to almost the certainty of the kind of serious neurological damage that means real learning disorders later in life.

So I think that there are none among us who have had that experience of walking through or actually holding these children in a neonatal intensive care unit who have or perhaps never did but could any further entertain the idea that drug use is a victimless crime. Clearly in the case of the pregnant woman, it is not victimless. She is the victim first, and the child that she delivers is very likely to be a serious victim.

I think that there are any number of horror stories, and we don't need to fill the pages of the record of this hearing with them, but one that I cannot help but find all but incredible is the case of a 2½-year-old child in foster care since his birth. The foster parents were quoted as saying that he routinely sticks his fingers into electrical sockets with seemingly no pain, that he continually puts himself to sleep by banging his head against the wall. What future does this child have?

What we are seeing with this epidemic is a story of hospitals under siege. It is not just the Martin Luther King Center in Los Angeles, the teaching hospital in Fresno in the heart of a rural valley. The San Joaquin Valley is reporting an incidence of between 15 and 20 percent of all newborns being exposed to some substance or another. In most cases in California it is crack.

As you pointed out in your statement, Mr. Chairman, it is a story of a foster care system that is strained beyond limit. I believe it was Dr. Fuller, director of public health from Milwaukee, who I first heard warn of the return of what we thought that an institution that America had consigned to history—the orphanage—be-

cause he said there simply will not be sufficient numbers of foster parents either willing or really able to deal with the enormous special problems that these children will bring.

He is right, not just in Wisconsin. In California, foster care placements have increased by 28 percent between 1986 and 1988. And as many as 60 percent of these drug-exposed infants have been placed in foster care, but I am hearing that it is increasingly difficult to place them.

It is a story of swamped educational and social service systems reeling from the onslaught of this drug epidemic, struggling to meet the educational and emotional and developmental needs of these drug-impaired infants and small children.

Some California school superintendents, some out in some of the rural counties, which are particularly financially pressed, report having reached their special education quotas for 1993 as a result of the recent increase of thousands of drug-exposed children in their school systems.

To give the subcommittee an example of the overall magnitude of the problem of maternal substance abuse in the State of California, it is estimated that 30,000 drug-exposed infants are born each year in my State. I happen to think that is underreported. In Los Angeles County alone, as I have indicated, the expectation is for 10,000 by 1993. You are going to hear later from witnesses that include Kathleen West, representing one of the Los Angeles hospitals which has been on the front line in the battle of dealing with the problem.

Mr. Chairman, the cost to society, obviously, as you have indicated, is not only measured in the more important terms of human suffering, but we are compelled at the policymaking level to measure it as well in costs of tax dollars. Last year, Californians provided an estimated $1 billion in support. And again, I suspect that is underestimated. The Nation presumably spent $13 billion. Again, I think that is low.

If I may invite your attention to the chart over here on the left, it is a representation of what we are advised by State and local agencies in California is the expectable, predictable costs, the special costs, short and long-term, of caring for a single drug-exposed infant. And they come to, on average, $134,000 per infant per year. That includes the special developmental services that are averaged at $70,000 per year for the State's developmental services costs. In terms of special compensatory education, it is estimated that those costs run at least $10,000 a year. Social service costs, which really relates to the compensation to foster care parents, run about $13,000 a year.

One of the points that I think we have all found in our different States is that when the parents of these children are habitual drug users, there is a much higher than normal incidence of child abuse on the part of the parents, and for that reason they occasion far more frequent intervention on the part of child welfare services, child protective services. The expected cost of that is about $11,000 a year.

Then, the medical costs, estimated at $30,000 for the initial costs, really do not include the long-term costs, which are almost incalculable.

But what it means very clearly, Mr. Chairman, is that what we are looking at in terms of the costs of a typical addicted newborn are placing incredible pressures on these systems, educational, health care, social service systems. And the prospect is that the pressure will only increase.

Now, as that chart illustrates, each of these drug-exposed infants—and if we accept the figure of 375,000 or 400,000 or 11 percent of all live births in this country each year as involving this kind of cost, well, it is obvious that that cost is going to be one that we can't say we can't afford it, we are going to be compelled to afford it unless we do something to prevent it. And that obviously has to be the focus of this hearing and of our efforts to try to prevent this tragedy and to prevent the necessity for costs of this kind.

The cost to society of the tragedy of maternal substance abuse during pregnancy is inestimable in terms of the human suffering. It is not beyond our ability to estimate but what we are seeing is, I think, on the low side. But if it is a tragedy that is impossible to fully estimate, at least we do know that it is preventable. Not easily so, but it is preventable. And both in terms of human suffering and in terms of the tax dollars involved, I think that we are compelled to take the kind of preventive measures that will eliminate to the extent that we can, or at least diminish insofar as it is possible for us to do so, the costs both human and financial.

So the question really is: How do we go about that? There have been some clinics that involve, in effect, outpatient care. There have been some success stories with that. Dr. Fonakura, whom I mentioned earlier, has had reasonable success with women who had sufficient strength of maternal instinct and sufficient strength of character to really come in in response either to an appeal by her or voluntarily, seeking some assistance.

But there are many who do not, and as Senator Kohl pointed out in his testimony, we do not begin in this country to offer the kind of either outreach or, if we had the outreach, the kind of treatment that is necessary for those who would come voluntarily because of a concern in an effort to try to do something early enough in their pregnancy to avoid the most serious damage to their children.

But there will be some who simply cannot summon the kind of strength that will be required to voluntarily submit to the rehabilitation that is necessary to get them clean.

My own view as to what we need to do is that we have to have both that kind of opportunity for those strong enough to come to it, and for those who simply are unable to come to it voluntarily there has to be the kind of either agency or court-directed, round-the-clock residential setting, voluntarily hopefully but where it is involuntarily nonetheless available and required so that there is some reasonable hope, some reasonable expectation that we will see women who have been through one pregnancy or in some cases multiple pregnancies, actually get clean so that there will not be a recurrence.

This view was, I think, very clearly and forcibly expressed in an op-ed last summer by the distinguished Harvard law professor and celebrated civil libertarian Alan Dershowitz. Professor Dershowitz declared that though he is pro-choice, as am I, he feels strongly that a woman who chooses to actually carry her pregnancy to term

is morally obliged to refrain from substance abuse or the kind of conduct during her pregnancy that will injure the health of the child and that the State has an entirely legitimate interest in seeking to secure the health of the child that the woman actually chooses to bear.

Simply stated, I think that we have to say to our selves that it is not punishment, rather it is prevention, to insist that a drug-addicted woman who has given birth to a drug-exposed infant submit to the kind of round-the-clock supportive treatment programs that are necessary to lead a drug-free life and thereafter to be able to give birth to healthy children. It can't be seen as cruel to subject a woman who needs that kind of support and that kind of reinforcement to a caring and supportive living environment where she can in fact learn to resist the temptation of drugs.

For those pregnant addicts who are simply unable to kick the habit voluntarily, we should require that they enter comprehensive treatment programs upon giving birth to a drug-exposed infant. Mandatory treatment is a preventive. It is rehabilitation. It is not punishment. And it is essential if we are to have any realistic hope of avoiding the kind of recurrence that has been the norm in all too many of these neonatal intensive are units.

Some will label this approach as a punitive exercise. Well, I emphasize it is not. I agree not only with Professor Dershowitz but also with perhaps someone whose testimony is even more relevant, one of the witnesses who was called to Senator Kohl's hearing, who is a graduate of Mandela House in Oakland.

You mentioned, Mr. Chairman, that Odyssey has only 25 beds. The Mandela House in Oakland has only six. It is the kind of round-the-clock residential setting that is essential. It takes months. It takes in fact 14 to 18 months to produce a graduate who has a reasonable chance of staying clean.

One of those witnesses who came to that first hearing called by Senator Kohl was Dawn Horrell, from the Mandela House, and when she was asked in the question-and-answer period about her experience in a court-ordered treatment program, she had this to say, and I quote:

"I am a strong person. Just imagine those people out there that are not strong. Just imagine those people who are not even in a program. It's very hard. I tried before I went to the program at Mandela House, and I couldn't do it."

Well, I think that she was strong, and she certainly spoke to us with great conviction. And for all the Dawn Horrells of America who have not stepped forward voluntarily, any policy response that fails to insist that those who can't do so voluntarily enter comprehensive drug treatment necessary to rehabilitate them so that they can get clean, any policy that fails to do that, Mr. Chairman, it seems to me is really turning a blind eye to the problem and not dealing with it comprehensively. Much worse, it says that we are condoning the repetition almost without end of a tragedy which in fact is preventable.

So, Mr. Chairman, I urge the subcommittee to take action on S. 1444, legislation that I was working on at the time of Senator Kohl's first hearing, legislation that I introduced as a first step

toward seeing to it that those who need that help who cannot voluntarily achieve it on their own, will find help.

And this is a basic point of conflict, I would emphasize. There are some who say that unless people come voluntarily to rehabilitation, it cannot be successful. Many of you, I think perhaps all of you on this panel, are familiar with the success of the Phoenix House program. Many of you, I am sure, know personally Dr. Mitch Rosenthal. He has been, I think, quite eloquent on the subject.

What he counseled me at the time that I consulted with him on preparing this legislation was—and this is if not verbatim, certainly the sense of what he said—"Don't let anyone kid you that rehabilitation cannot be successful unless it is purely voluntary. That is simply not true. People have been brought kicking and screaming to Phoenix House. They have left clean and able to function in society, notwithstanding the fact that they did not want to come, resisted coming, and for a long time after being there continued to resist rehabilitation."

So I think that we have got to provide outreach, we have got to provide treatment for those who come voluntarily, and that would be a major cost. But, Mr. Chairman, when you look at this cost, it is very clear that the failure to provide for the kind of rehabilitation that will actually get women who are abusing drugs or alcohol during pregnancy clean so that they do not have a recurrent pattern is going to save us all of these costs, not to mention the incalculable human tragedy that is, I repeat, preventable.

S. 1444 is a demonstration program. It would authorize $50 million for five straight treatment demonstration projects. Mr. Chairman, two important goals must be met by grant applicants who are seeking funding under that legislation: First, there does have to be aggressive preventive outreach and education efforts pursued by the State that is applying, to identify pregnant substance-abusing women, in the hope of minimizing the long-term effects upon the child. And once identified, these women must be afforded the opportunity to voluntarily rid themselves of their addiction.

But second, for those women who give birth to substance-exposed infants, those who do not have the capability of coming voluntarily early enough in a pregnancy to avoid that damage to their child, the recurrence must be prevented through comprehensive drug rehabilitation, which includes mandatory rehabilitation, not in a punitive but in a preventive way. We are not putting people in prison. We would be putting them in Mandela House, in Odyssey, in that kind of setting.

Mr. Chairman, you have the legislation before you. You have been generous with your time. I greatly appreciate it. You were correct in your initial assessment that this is a subject about which I feel not just strongly, I will say passionately. I think that those of us who have witnessed this tragedy can hardly feel any other way.

Thank you, Mr. Chairman.

[The prepared statement of Senator Wilson follows:]

PREPARED STATEMENT OF SENATOR WILSON

Senator WILSON. Thank you, Mr. chairman, and members of the subcommittee for holding this important and timely hearing on the issue of maternal substance abuse

during pregnancy and this problem's impact upon our Nation's child welfare system.

Crack babies. Border babies. They number in the hundreds of thousands—375,000 according to recent projections by the National Association of Perinatal Addiction, Research, and Education.

If there remain any who persist in the delusion that use of illegal drugs is a victimless crime, let them walk through a neo-natal intensive care ward full of babies innocently addicted to crack or PCP or alcohol.

They writhe in their cribs in maternity wards across the Nation, emitting high pitched cries of pain. Even the most experienced, most caring nurses cannot calm them. They are the innocent victims of child abuse through the umbilical cord. For each 20 minute rush experienced by their mothers during pregnancy, these infant receive a 72 hour high.

The tragic story of drug-exposed infants is one of human pain and suffering. Consider the case of James who, at 2½ and in foster care since his drug-exposed birth, "routinely sticks his fingers into electrical sockets without a wince and rocks himself to sleep by banging his head against the wall."

It's a story of hospitals under siege. Some California hospitals report that 20 percent of babies born each month are crack-exposed.

It's a story of a foster care system strained beyond its limit. In California, foster care placements have increased by 28 percent between 1986 and 1988. As many as 60 percent of drug-exposed infants have been placed in foster care.

It's a story of swamped educational and social service system reeling from the onslaught of the drug epidemic and struggling to meet the educational, emotional, and developmental needs of drug-impaired infants and children. Some California school superintendents report having reached their special education quotas for 1993 as a result of a recent increase of thousands of drug-exposed children in the schools.

To give the subcommittee an example of the overall magnitude of the problem of maternal substance abuse in the State of California, it is estimated that nearly 30,000 drug-exposed infants are born each year in my State. In Los Angeles County alone, 10,000 drug-exposed infants are expected in maternity wards by 1993.

Later this morning the subcommittee will hear from Kathleen West representing one of the Los Angeles hospitals which has been on the front line in the battle to deal with a problem which has reached epidemic proportions.

Mr. Chairman, the cost to society to care for drug-exposed infants is staggering. Last year, Californians provided $1 billion in support. The Nation spent an estimated $13 billion.

If I could direct the subcommittee's attention to the chart in front of me, I would like briefly to outline the short- and long-term costs we will face if we do not act on the problem of maternal substance abuse.

As the chart illustrates, each drug-exposed infant—and remember 375,000 or 11 percent of all live births in this country each year involve a drug-exposed infant—will cost us roughly $134,000 annually in social, educational, and health care services throughout his or her life. I should emphasize that this figure does not include long-term medical costs.

These costs do include $30,000 for initial health care and delivery of the infant, $11,000 per year for child welfare agency investigations of child abuse and neglect, $13,000 per year for foster care placement, $10,000 per year for special education services, and $70,000 per year for State development services.

The cost to society of the tragedy of maternal substance abuse during pregnancy in terms of human suffering is simply inestimable.

How do we estimate the cost of diminished physical and mental capacity? How do we determine the cost of a lifetime of broken dreams and heartbreak?

It is a tragedy impossible to measure fully, but thank god, it is preventable. Though expensive, we have to provide widely available, quality preventive outreach and treatment that will allow mothers capable of turning away from substance abuse to do so early in their pregnancy to prevent even greater injury to their babies.

I have pursued and will continue to pursue increased funding for these types of preventive efforts. However, this response in and of itself is not adequate.

How do we assist those substance abusing women who because of the fiercely addictive and destructive nature of crack are rendered unable to step forward for treatment and who give birth to a substance exposed infant? How do we ensure that they will not give birth to 2, 3, or 4 more drug-exposed infants?

For those women whose diminished capacities prevent them from availing themselves of treatment opportunities and who give birth to drug-exposed infants, I

submit that we must insist they enter the king of caring, comprehensive treatment necessary to break the cycle of addiction.

My own view was clearly and forcibly expressed in an op-ed last summer by Harvard law professor Alan Dershowitz, a celebrated civil libertarian. Dershowitz declared that though he is "pro-choice"—as am I—he feels strongly that a woman who chooses to carry her pregnancy to term is morally obliged to refrain from substance abuse or conduct during pregnancy that will injure the health of her child . . . and that the State has an entirely legitimate interest in seeking to secure the health of the child she may choose to bear.

Simply, we must ask ourselves: Is it punishment to insist that drug-addicted women who have given birth to a drug-exposed infant submit to the kind of round-the-clock, supportive treatment programs they need to lead a drug-free life and give birth to healthy babies? Is it cruel top subject women to a caring and supportive living environment where she can learn to resist the temptation of drugs?

Mr. Chairman, I think not.

For those pregnant addicts who are unable to kick their habit voluntarily, we should require that they enter comprehensive treatment programs upon giving birth to a drug-exposed infant. Mandatory treatment is a preventive and rehabilitative approach essential to their own health, to that of their infant, and to the health of future children.

Some have labeled this approach as purely a punitive excerise. It is not. It is a preventive action which offers us the best hope to end the tragedy of maternal drug abuse during pregnancy. Just speak to the addict.

During a Government Affairs Committee hearing last August on the issue of maternal substance abuse during pregnancy, Ms. Dawn Horrell, a graduate of the Mandela House drug treatment program in Oakland, CA, when asked about her experience in a court-ordered treatment program had this to say: "I'm a strong person. Just imagine those people out there that are not strong—not even in a program. It is very hard. I tried before I went to the program (Mandela House)—I couldn't do it."

For the Dawn Horrells of this Nation who have not stepped forward voluntarily, any policy response failing to insist they enter the comprehensive drug treatment needed to come clean represent a failure on our part. Much worse, it says we condone condemning generations of innocent American children to live literally the life of the damned.

Mr. Chairman, I urge the subcommittee to take action on S. 1444, legislation which I have introduced as a first step toward seeing to it that substance abusing pregnant women get the treatment they need. It offers a compassionate response to a tragic problem which affects us all.

S. 1444 would authorize $50 million for 5 State treatment demonstration projects.

Briefly, Mr. Chairman, two important goals must be met by grant applicants under my legislation.

First, aggressive preventive outreach and education efforts must be pursued to identify pregnant substance abusing women in the hope of minimizing long-term effects upon the child. Once identified, these women must be afforded the opportunity to voluntarily rid themselves of their addictions.

Second, for those women who give birth to substance exposed infants, recurrence must be prevented through comprehensive drug rehabilitation.

I would ask that a summary of my legislation be included in the hearing record.

Mr. Chairman, thank you for indulging me this morning. I look forward to working with the subcommittee to develop an appropriate Federal response. As a nation and as a compassionate society, we cannot afford to continue to lose 11 percent of our newborns to the scourge of drug abuse. We must take action to end the tragic problem of maternal substance abuse during pregnancy today.

Senator DODD. Thank you very much.

Senator Kohl, we thank you as well for being here this afternoon, and we look forward to working with you.

I am going to put the meter on here.

Senator WILSON. Mr. Chairman, let me add one thing. May I ask unanimous consent to have this op-ed by Professor Dershowitz included in your record? You have probably all seen it, but if not, I think it is an eloquent argument.

Senator DODD. Without objection, it will be included in the record.

[The article of Mr. Dershowitz follows:]

Drawing the Line on Prenatal Rights

When a Pregnant Woman Abuses Her Health, Should the State Intervene on Behalf of Baby?

There is a dangerous implication in some pro-choice arguments that may frighten the Supreme Court into restricting or even overruling Roe *v.* Wade, the 1973 decision that established women's right to abortion. The implication is that the right to abortion also precluded the State from requiring women to take any degree of prenatal care after they make the decision not to abort.

Syndicated columnist Ellen Goodman recently suggested this in criticizing the Bush administration's efforts to overrule Roe *v.* Wade. She wrote: "There are suggestions among those who talk of fetal rights that the Government could constrain a pregnant woman's diet and physical activities, stamp out her cigarettes, empty her wine glass—or else." Goodman also invoked the specter of mandatory testing and treatment for the fetus.

Now, I am not a "fetal-rights" advocate. I favor Roe *v.* Wade. I believe that a pregnant woman should have the right to choose between giving birth or having an abortion. But I am a human-rights-advocate, and I believe that no woman who has chosen to give birth should have the right to neglect or injure that child by abusing their collective body during pregnancy.

Once a woman has made the decision to bear a child, the rights of that child should be taken into consideration. What happens to the child in the womb may have significant impact on his or her entire life. One example is the woman who drank half a bottle of whiskey a day while pregnant and gave birth to a mentally retarded child. She is now suing the whiskey company for not warning her about the relationship between heavy drinking during pregnancy and birth defects. Anyone who has spoken to an inner-city obstetrician is aware of the near epidemic of birth defects among babies born to heavy drug users.

This is not to argue for intrusive governmental rules on occasional drinking or smoking. But at the extremes, there is a compelling argument in favor of some protection for the future child against maternal excesses that threaten to cause enduring damage. Once a woman decides to give birth, a balance must be struck between her rights during the 9 months of pregnancy and the equally real rights of her child during its life span. I believe that the balance should generally be struck in favor of the woman's privacy and against the power of State compulsion. But a balance, nonetheless, must be struck.

My colleague, Professor Laurence Tribe, agrees with Goodman and argues as follows: "There's no principled way to say that the Government can use women's bodies against their will to nurture the unborn without accepting the other serious and totalitarian implications about privacy." With respect, I disagree.

There is a principled distinction between totalitarian intrusions into the way a woman treats her body, and civil libertarian concerns for the way a woman treats the body of the child she has decided to bear. That principled distinction goes back to the philosophy of John Stuart Mill and is reflected in the creed that "your right to swing your fist ends at the tip of my nose." In the context of a pregnant women's rights and responsibilities in relation to the child she has decided to bear, the expression might be: "Your right to abuse your own body stops at the border of your womb."

Of course, any recognition that a future child may have rights—even limited ones—in relation to its mother, may be grist for the "right to life" mill. Anti-abortionists will argue that if a future child has the right not to be damaged during pregnancy, then it follow that the fetus has the even more important right not to be killed—i.e., aborted.

But the second conclusion does not necessarily follow from the first. Under Roe *v.* Wade, a fertilized egg, or even a biologically more advanced fetus, has no right to be born unless the mother chooses to give birth. But it does not follow as a matter of constitutionality, principle or common sense, that a woman has the right to inflict a lifetime of suffering on her future child, simply in order to satisfy a momentary whim for a quick fix.

A principled person can fully support a woman's right to choose between abortion or birth, without supporting the very different view that the State should have no power to protect the health of a future child. The State should begin by making prenatal care available to every pregnant woman. But we need not be frightened, by

the specter of totalitarianism, from considering reasonable regulations designed to reduce the serious long-term problems caused by pregnant women who abuse their future children.

Proponents of a woman's right to abortion should not weaken their powerful argument in favor of a woman's right to control her body.

And, in the eyes of many who support choice, they do weaken it when they link it to the far weaker argument denying the State the power to protect babies who are to be born.

Senator DOD. We will now invite our panel of witnesses to join us here, and I am going to put the clock on here. I apologize, but we have to move along here.

Our first witness is Dr. Herb Kleber, the deputy director for Demand Reduction of the Office of the National Drug Control Policy, the Executive Office of the President.

Doctor, we thank you very much for joining us here today.

Dr. Kleber will describe the effects of crack on babies, which ranges from addiction to severe damage to more subtle effects associated with later learning ability. Estimates of severely affected babies range from 35,000 to 385,000.

So, Doctor, we thank you for joining us today, and we will try and move this along. We appreciate your patience.

By the way, your entire statement will be made a part of the record, so have no hesitancy on that point at all. If you would care to paraphrase your remarks, then we will try to get to the questions.

STATEMENT OF HERBERT KLEBER, M.D., DEPUTY DIRECTOR FOR DEMAND REDUCTION, OFFICE OF NATIONAL DRUG CONTROL POLICY, EXECUTIVE OFFICE OF THE PRESIDENT

Dr. KLEBER. Thank you. Let me do that in the interest of saving time. Let me first thank you, Mr. Chairman, for inviting me to testify before you on the important and distressing subject of babies born affected by drug use.

Before coming here this afternoon I gave the lunchtime address to a workshop on children in perinatal and parental illicit drug use, sponsored by the National Research Council and the Institute of Medicine, and later at that meeting had the opportunity to hear one of your later witnesses, Dr. Ira Chasnoff, and my recent travels have taken me to St. Petersburg, where I had the opportunity to view the splendid program run by, again, one of your later witnesses, Shirley Coletti. Operation PAR is one of the very few comprehensive programs that I have encountered in my travels, and for those who get to Florida I urge you to visit it. It is truly a superb program.

I am also delighted to see that my old colleague from Connecticut, Amy Wheaton, who has done such a splendid job there, is also one of your later witnesses.

It is clear that the problem of crack babies, or babies born affected by drug use, is a major problem in the United States. In my 25 years of treating drug addicts, it has been one of the most tragic areas that we have encountered.

Until recently, the majority of drug abusers have been male. The advent of crack has modified that, and although the majority of people using cocaine are still males, we now find in a number of

areas of the United States that the number of female crack addicts exceeds that of male crack addicts.

Unfortunately, one of the most fundamental questions concerning the issue is not really answered: How many of these infants there really are. There is even confusion as to who they are. We don't know whether crack babies—and some of the articles refer just to "babies born addicted"—or those who have a drug in their umbilical cord blood when they're born. We know that not all babies exposed to illicit substances during pregnancy are immediately apparent as being harmed, but some of them may, three, four, five years later demonstrate learning deficits and difficulty in adjusting to the academic environment.

I am not going to get into a lot of the symptoms, what happens to these things like the low birthweight, the severe brain damage or the intense symptoms of withdrawal that prevent bonding because these infants can't be held without crying; touching them is painful.

But the key point is we need to learn how many of these youngsters are there. We need to have much better data so that we can plan a rational response. As Senator Adams and others have noted, we have estimates anywhere between 30,000 and 375,000. Our office has estimated 100,000. We can't afford to play these numbers games if we are trying to develop a rational policy. So, both NIDA and the Centers for Disease Control have surveys under way which should give us a much better idea of what we're up against.

Clearly, regardless of the number, there are far too many of these babies and finding a solution to their plight, however difficult, is a priority in the President's national strategy. We have three challenges:

(1) To get those addicts, especially those who are pregnant, to stop their behavior which is destructive to themselves and to the children they're carrying; (2) to help those infants who are born handicapped get the care that they need; and (3) to prevent further drug use.

Ultimately, that is going to take a mixture of supply and demand reduction measures. We need not only treatment but prevention, and the criminal justice system, as Senator Wilson noted, involuntary treatment can be just as successful as voluntary treatment. Our program demonstrated that in 1975, and other programs have demonstrated that since, that if you can get them there regardless of whether it's voluntary or involuntary and compel them to remain in treatment, they can be significantly helped.

So that pregnant addicts who are in the custody of the criminal justice system, if I had my way, would be required to remain in residential treatment or outpatient treatment as long as they remain drug-free until after their delivery. Unfortunately, right now there is an inadequate number of treatment programs equipped to accept such individuals.

For those pregnant addicts who are not involved with the criminal justice system, outpatient efforts and residential efforts are needed. We need better outreach methods to reach them and get them to accept the care.

In order to accomplish these goals, the national strategy provides for significant additional resources for our pregnant addicts and

their children through outreach treatment and research initiatives, through the State action grants. And if we get the legislation that we have asked for, we will be able to do a much better job.

I should note that one of the great disappointments to me in this position was the failure of Congress last session to enact the presidential amendment related to Statewide treatment action plans. They would instill accountability into the Nation's treatment system, provide crucial information, and enable us to make sure that programs for women in general and pregnant addicts in particular are developed by the States so that we could hold them accountable.

I know that both chambers resoundingly passed this amendment, and yet it became tied up in conference committee due to other issues. I would encourage you and ask you for whatever help that you can give us in getting this passed.

Other things that the strategy calls for is additional funds to the Office of Substance Abuse Prevention for grants to support demonstration programs on prevention, education, early intervention, and the National Institute on Drug Abuse will be making funds available for treatment, research for development of new medications for research, and for demonstration grants.

I am optimistic about increased efforts by NIDA to learn how drugs taken by the mother affect intrauterine development and how babies born to those mothers can best be treated. For example, medication that could block the effects of drugs or decrease craving for them without harming the fetus would be very valuable in treating pregnant addicts. Work that is undergoing now to develop agents that would not pass through the placenta would be very valuable.

And finally, we need to understand how much environmental intervention could reverse the effects of the chemicals on the child once it is born.

These are just some of the ways that the national strategy proposes we address the complicated and serious problems of drug-affected children. It is important for us to realize that this problem is but the most serious manifestation of the broad devastation drugs have caused. We will be no more successful helping pregnant addicts and their offspring than we are in reducing drug consumption across the board.

We can and should take heart from scattered indications that the Nation's current cocaine epidemic is no longer spiraling out of control and may be leveling off. But we can't let up. Much more remains to be done.

I look forward to working with you and your colleagues in the weeks and months ahead, and I can assure you that we will be keeping an eye on the problem posed by Senator Adams; that is, the development of new drugs such as ice and the problems they create and the upsurge, as we are learning recently, of heroin. So we are not just focusing on cocaine, we are trying to keep an eye on all these substances.

I thank you, and I will be delighted to answer any questions you might have.

[The prepared statement of Mr. Kleber follows:]

OFFICE OF NATIONAL DRUG CONTROL POLICY
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Washington, D.C. 20500

PREPARED STATEMENT OF HERBERT D. KLEBER, M.D.

Mr. Chairman, members of the committee, thank you for inviting me to testify before you on the important and distressing subject of babies born affected by drug use.

I have been working in the field of drug abuse for nearly twenty-five years, and no single phenomenon has demonstrated to me the destructive power of drugs as vividly as babies who have been exposed to crack and other drugs before birth. Government and private sector leaders must work together to find careful and rational approaches to this problem.

During the past decades, the vast majority of users of illicit drugs in America have been men. Crack cocaine in 1985 somewhat altered that pattern. Even though the rate of cocaine use is still twice as high for men than for women, there are now unprecedented numbers of female addicts, many of whom are pregnant or are of childbearing age.

Unfortunately, one of the most fundamental questions concerning this issue is not readily answered, the question of how many "crack babies" there actually are. The first obstacle

to finding an answer is confusion as to what we mean by "crack baby." We know that all babies who are exposed to drugs, including crack, do not suffer equally. Some are, in fact, born addicted to cocaine, and are found to have smaller head circumference, low birth weight, severe brain damage, and because of withdrawal, cannot be touched or held during the days following delivery.

Other children, who are sometimes referred to as "crack babies," have been exposed to cocaine or other drugs in utero, but are not, in fact, born addicted or significantly impaired. However, they may later suffer problems such as attention deficit disorder and other learning disabilities. Surprisingly, some drug-exposed babies escape physical and mental harm.

The available data leaves much to be desired, and there remain great differences among estimates of the prevalence of this problem. Some experts have estimated that there are at least 30,000 and others as many as 375,000 babies who have been born addicted to, or severely impaired by, drugs.

Determining accurately the depth and breadth of the problem is important, and both the National Institute on Drug Abuse and the Centers for Disease Control have surveys underway which will give us a much better idea what we are up against. Regardless of the number, there are too many of these babies, and finding solutions to their plight, albeit difficult, is a priority in the President's National Strategy.

The challenge before us is three-fold. First, female

addicts, especially those who are pregnant, must be pushed and helped to stop their behavior which is destructive to themselves and to the children they may be carrying. Second, children who have already been brought into this world severely handicapped by their mothers' use of drugs need special attention and the care of loving hands. Third, we must prevent further drug use, and the addiction that follows, by all members of society -- including women of childbearing age. It is clear our society can neither afford nor manage large numbers of "crack babies."

This particular aspect of the anti-drug effort must be solved, ultimately, through a mix of supply and demand reduction activities. The criminal justice system, drug treatment, and drug prevention efforts must all be brought to bear in unprecedented cooperation if we are to make a difference.

Unfortunately, pregnant addicts are often among the most reluctant to seek treatment, and many treatment programs are not equipped to accept them. Pregnant addicts in the custody of the criminal justice system can sometimes be required to remain in residential treatment until after they deliver. But outreach efforts are needed for other pregnant addicts, who must willingly enter and remain in treatment programs providing pre-natal and post-partum care for them and their children.

With the goal of finding solutions to these complicated problems, the National Strategy calls for significant additional resources for pregnant addicts and their children in outreach, treatment, and research initiatives. Through State treatment

action plans proposed by the President, States will be held accountable for providing improved and expanded outreach efforts and treatment programs for pregnant addicts. The Office of Substance Abuse Prevention (OSAP) will award grants in Fiscal Year 1991 to support demonstration programs on prevention, education, and early intervention. The National Institute on Drug Abuse (NIDA) will make funds available for Fiscal Year 1991 demonstration grants for research and development of outreach as well as safe and efficacious treatment services to pregnant addicts and their children.

As an aside, let me say that Congress' failure last session to enact the President's amendment related to Statewide Treatment Action Plans was a great disappointment to me. These plans would instill accountability into the Nation's treatment system and would provide crucial information not just in the area of drug-exposed babies, but across a wide range of treatment issues. I know that both chambers resoundingly passed this amendment, and yet it became tied up in conference committee due to other issues. Congress has appropriated significant resources to drug treatment in recent budgets. Our amendment would help ensure that funds are spent on the most effective programs.

As a clinician and scientist, I am optimistic about increased efforts by NIDA to learn how drugs taken by the mother affect intrauterine development and how babies born to addicted mothers can best be treated. For example, medication that could block the effects of drugs or decrease craving for them without

harm to the fetus would be extremely valuable in treating pregnant addicts. Pioneering work is being initiated to develop treatment agents that would not pass through the placenta to harm the unborn child, and to develop treatments that could alleviate the effects of drugs on newborn infants.

These are just some of the ways in which the National Strategy proposes we address the complicated and serious problem of drug-affected children. It is also important for us to realize that this problem is but the most serious manifestation of the broad devastation drugs have brought to our country. We will be no more successful helping pregnant addicts and their offspring than we are in reducing drug consumption across the board.

We can and should take heart from scattered indications that the Nation's current cocaine epidemic is no longer spiralling out of control and may be levelling off. But we cannot and will not let up. There is much more that remains to be done. I look forward to working with you and your colleagues in the weeks and months ahead.

This concludes my statement, and I will be happy to answer any questions you may have at this time.

Senator DODD. Thank you very much, Doctor.

Let me first of all commend you for the fine work you have been engaged in. I consider one of the more—and I mean this—one of the more pleasurable times I have spent in talking with administration officials to be our hour and a half or so meeting. It was going to be a 15-minute meeting or so, and it turned into about an hour and a half meeting, as I recall, when you were in my office. I was so fascinated with your own observations and thoughts on this overall problem. It is truly a pleasure to have you in Government service.

Dr. KLEBER. Thank you.

Senator DODD. The country is very fortunate indeed to have someone of your talents and ability working on this kind of a problem.

By the way, there is a vote on, and Senator Coats is running over to make that vote and will come back. I will try to get through my questions here so we can move this process along. I can see the long faces on some of our witnesses. Senators have a tendency to be a little verbose from time to time.

Dr. KLEBER. To say nothing of witnesses.

Senator DODD. No, not true of witnesses at all.

In your statement you mention outreach efforts that are needed for pregnant addicts to get them into treatment and prenatal care. I wonder if you have any ideas that you could share with us about how such outreach can be accomplished. Possibly there are some programs on the State or local level which are particularly successful.

Obviously, the best thing is to get them in voluntarily. I don't disagree that you do what you can, but I think the statistics show that the most successful programs are ones where people voluntarily come in, in terms of the rate at which a person recovers, where the persons themselves have made the decision to seek treatment. I don't know if there is much debate about that.

But I wonder if you might describe some of the programs where outreach works.

Dr. KLEBER. Well, there are a number of ways to do outreach. One, through training of physicians. One of the things you may be hearing this afternoon from Dr. Chasnoff is that this is not a problem of the inner city, that the percentage of drug abuse among the majority population in the suburbs is about identical to that among inner city. The difference is that the inner-city group tend to be seen in clinics, and the outer city and suburban group in private physicians' offices.

So one outreach effort is, clearly, training health professionals to recognize this in their patients and equipping them with the knowledge to identify it and with the knowledge of what to do about it when they identify it.

Two, working in other kinds of health services. And there is a commission that has been ongoing that tries to look at improvement in maternal care and the mainstreaming of this, so that hopefully women who come into any kind of health services would be counseled about this and encouraged.

There are programs that go into the community. Again, at this seminar I was at lunch, one woman mentioned that there needs to

be outreach that goes on between 11:00 and 7:00 a.m. to reach a lot of these women, that they are in the streets. And if you are going to reach them, you have to have outreach workers going into the community to where they are.

In New Haven, before I left, we had developed a program with a bus going around into impacted neighborhoods, providing free maternal checkups and infant care to encourage women to come to talk to us, to then encourage them to seek treatment if they needed it or to get their significant others who are addicts into treatment.

So there is a variety of these approaches that are going on, and I think a number of them are successful.

Senator DODD. Well, I am glad to hear that.

You may want to submit to us some very specific approaches from across the country we might want to look at in terms of their success rate.

In your statement you discuss the national strategy's call for additional resources for treatment of pregnant addicts and their children. What is the gap currently, if you would share with us, between the number of women who need treatment and the number of suitable treatment slots available, and how do you propose to fill that gap?

Dr. KLEBER. Well, it's hard to know exactly how many women need treatment. As I indicated, the numbers on that are very soft, and you have heard the range.

Senator DODD. Well, aren't the numbers for different things? I mean the number, I thought 375,000 was the total for substance abuse in general where 100,000 was cocaine or crack, rather.

Dr. KLEBER. But that 375 is also a squishy figure.

Senator DODD. Yes, but it's broader than just cocaine.

Dr. KLEBER. It's a much larger number than just cocaine.

Senator DODD. Yes.

Dr. KLEBER. But whether that is 375 or 3 or 250, you can get scientists and epidemiologists arguing. So I am not sure of the size of the gap. The fact that there is a significant gap, there is no question on.

Senator DODD. But how many are getting treatment? We must have some idea of that.

Dr. KLEBER. No. Unfortunately, the Congress removed from NIDA in the early 1980's the ability to require the States to provide information on exactly how many people are in treatment and their characteristics. So that the N-data study, which is the main instrument to do that, has been voluntary. Many of the States do not comply, or they comply erratically. We don't have a good idea of what the treatment system looks like.

So I will say there is a large gap, but I am not prepared to say just how large the gap is.

Senator DODD. You mentioned, of course, the reluctance of pregnant addicts to seek treatment. Could part of that problem be just the inadequacy of treatment facilities around? Is there a relationship there between the availability of treatment and the reluctance of the pregnant addict?

Dr. KLEBER. That is certainly one of the features. Most treatment programs do not like taking the pregnant addict, for a variety of

reasons, including legal concerns: If the woman has a miscarriage, are they responsible? Or because they don't know how to treat them.

Often, the woman will only come to treatment if she can bring young children with her, and most of the programs are not equipped to be able to do that. So that first you have the problem of getting the woman to seek care, and then you have the problem of having adequate programs for her when she does seek care.

And right now, the system is very inadequate.

Senator DODD. Well, I thank you very much for these comments.

Senator Coats may be a little while in getting back. What we may do is submit some additional questions to you.

Dr. KLEBER. We would be happy to respond.

By the way, I have with me Dr. Bruce Carnes, who is our director of planning and budget. If there are any specific monetary figures that you have a question about, Dr. Carnes would be happy to address himself to them.

Senator DODD. Terrific. Thank you very much.

I know Senator Coats will want to submit some questions as well, and other members of the panel. We thank you for being here today.

Dr. KLEBER. Thank you.

Senator DODD. The subcommittee will take a recess. In the meantime, we will ask the second panel to join us here at the table when we come back, and we will get under way. [Recess.]

Senator COATS. [presiding.] We would like to call the second panel to the witness table: Mr. Mangano, Dr. Chasnoff, and Dr. Wheaton.

Mr. Mangano, we will start with your testimony.

STATEMENTS OF MICHAEL F. MANGANO, DEPUTY INSPECTOR GENERAL FOR EVALUATIONS AND INSPECTIONS, DEPARTMENT OF HEALTH AND HUMAN SERVICES; DR. IRA J. CHASNOFF, PRESIDENT, NATIONAL ASSOCIATION FOR PERINATAL ADDICTION RESEARCH AND EDUCATION, CHICAGO, IL; AND DR. AMY B. WHEATON, COMMISSIONER, DEPARTMENT OF CHILDREN AND YOUTH SERVICES, HARTFORD, CT

Mr. MANGANO. Thank you very much. I am pleased to be here with you this afternoon to present the results of our recent study on crack babies.

The purpose of our study was to take a look at the effect of crack babies on the child welfare system in the country today. In doing our study, we examined 12 metropolitan areas across the country. Only eight of those metropolitan areas were able to identify the number of crack babies reported to child welfare systems in the last year. That number was 8,974. We believe that is at least half under reported. So we are comfortable with the President's national drug control strategy of 100,000 crack babies per year as a base.

The cost of hospital delivery and perinatal care and foster care for those children, that 8,974, through age five would be approximately a half a billion dollars. That would include no other expenses for early developmental, education, and other health care costs, and of course no services after age five.

We were surprised to find that most of the crack babies do look healthy at birth and are not identified at birth. In fact, many of them, the problems that will occur will appear a year or two later. Most hospitals don't test the mothers for drugs. And that is another reason why they are not being identified at birth, and in fact they rely on self-reporting in most cases, which we found to be a highly unreliable way of doing it.

The long-term effects are not now known, but we think they could be severe. Mothers that we found in doing our study were generally older than we thought, from age 25 to 28, with two to four other children, and primarily black, some Hispanic, and even fewer whites.

The child welfare system is really struggling to cope, with some doing better than others, but some having tremendous difficulty. Caseloads are increasing, primarily due to problems of drug abuse, and the kinds of cases that they are becoming involved with with crack babies are far more complicated and sophisticated than the ones that they have been used to dealing with.

The cases involve usually tracking mothers who abandon their children, emergency placement, parental drug treatment. Caseworkers' jobs are becoming far more dangerous. There is higher turnover and higher caseloads.

Few States require hospitals to report positive drug testing to child welfare services, which creates a problem.

We did find some good news, which we are going to be putting together in a report in about six weeks that will be dealing with some of the effective practices we found across the country.

But some of the things we can mention here today are: the establishment of high-risk child welfare services baby units, specialized training for child welfare service workers, reduced caseloads, service zones decentralized in the cities so that the child welfare service workers would be located in the neighborhoods that the babies would be coming from, and courts fast-tracking cases through the system to make placements.

Hospitals, because of the enormous cost of the crack baby phenomenon, are also beginning to get involved in child welfare services and recruiting foster parents themselves and locating services for the mother and the child.

Case management for this population becomes absolutely essential. They need to guide the mother and the child through the maze of services, including education, health care, counseling, physical therapy, and drug rehabilitation.

Most crack babies do go home with their mothers, although 30 to 50 percent of them end up in foster care. More placements, though, are needed. In 1986, 280 placements were needed for foster care. Three short years later, that was up to 360,000.

Some of the problems in identifying good foster parents are the low reimbursement rates that are available, the need for more black families, and the need for training and support services for those foster care workers.

Some of the children do go to emergency placement. These are 30-to-90-day placements, and congregate care.

We did find in seven of the cities at least one residential drug treatment center where the mother and child can go to from six

months to two years. That's the good news. The bad news is that there are very few of them nationally.

The adoption process is too long and too expensive. In the experience of the 12 metropolitan areas we went to, the adoption process is taking up to three years. Some of the bars that they are having to deal with have to do with prohibitions against interracial adoption, fear of long-term effects of these kids, and the 72-hour voluntary waiting period that the parents have to relinquish their parental right to their children.

People across the country are worried about prenatal drug exposure, not just crack. In our report we make some recommendations for State and local Governments as well as for the Federal Government. With the State and locals, we recommend that they very aggressively go out and improve their outreach program to provide prenatal care to at-risk pregnant women. They need to reduce the barriers to foster care and adoption and develop guidelines for training of caseworkers to help them identify drug abusers and treat the parents as well as the children.

At the Federal level we are asking for a continuation and heightened effort at long-term research both into the effects of drugs on babies, treatment methodologies, and placement options. We want to promote the drug abuse training at medical schools and child welfare service agencies, to identify and treat children. And we also want to support the expansion of prenatal care and prevention.

We have three additional studies that we will be working on over the next several months we want to let you be aware of. One is on the termination of parental rights. The second is to examine State child abuse laws affecting prenatally drug-exposed babies. And a third study is on foster care group homes. We have heard this afternoon the mention of orphanages is starting to crop up.

Thank you very much, and we would be happy to answer any questions you have.

Senator COATS. Thank you very much.

[The prepared statement of Mr. Mangano follows:]

PREPARED STATEMENT OF MICHAEL F. MANGANO

GOOD AFTERNOON, MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE. I AM MICHAEL F. MANGANO, DEPUTY INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. WE ARE HERE TODAY, AT YOUR REQUEST, TO SHARE WITH YOU THE RESULTS OF OUR STUDY ON CRACK BABIES.

BACKGROUND

AS YOU KNOW, CRACK IS COCAINE IN A SMOKEABLE FORM. ACCORDING TO THE NATIONAL INSTITUTE ON DRUG ABUSE (NIDA), OVER 5 MILLION WOMEN OF CHILD BEARING AGE ARE USING ILLEGAL SUBSTANCES. ONE MILLION OF THESE WOMEN ARE USING COCAINE. THE PRESIDENT'S NATIONAL DRUG CONTROL STRATEGY REPORT HAS ESTIMATED THAT EVERY YEAR 100,000 BABIES ARE BORN EXPOSED TO CRACK.

PRENATAL EXPOSURE TO COCAINE CAN LEAD TO PREMATURE BIRTH, LOW BIRTHWEIGHT, BIRTH DEFECTS, AND RESPIRATORY AND NEUROLOGICAL PROBLEMS. CRACK BABIES HAVE A SIGNIFICANTLY HIGHER RATE OF SUDDEN INFANT DEATH SYNDROME (SIDS) THAN BABIES NOT EXPOSED PRENATALLY. WHILE EXPERTS BELIEVE THAT MANY CRACK BABIES WILL SUFFER DEVELOPMENTAL DISABILITIES, THE FULL RANGE OF LONG-TERM EFFECTS OF PRENATAL COCAINE EXPOSURE ARE NOT NOW KNOWN.
WHEN CRACK BABIES ARE IDENTIFIED, LOCAL CHILD WELFARE AGENCIES ARE USUALLY NOTIFIED TO PROVIDE PROTECTIVE SERVICES, SOCIAL

SERVICES, OR FOSTER CARE. HOWEVER, THESE AGENCIES ARE OFTEN UNABLE TO MEET THE NEEDS OF CRACK BABIES AND THEIR MOTHERS.

INSPECTION PURPOSE AND METHODOLOGY

THE HHS ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES REQUESTED WE LOOK INTO HOW CRACK BABIES IMPACT CHILD WELFARE SYSTEMS AROUND THE COUNTRY. IN OUR RESEARCH, WE FOUND THAT LITTLE DEFINITIVE DATA EXISTS AT THE NATIONAL LEVEL.

DURING THE LAST 3 MONTHS OF 1989, WE TALKED IN-PERSON WITH OVER 200 PEOPLE FROM 12 METROPOLITAN AREAS AROUND THE COUNTRY. THESE CITIES WERE CHICAGO, FORT WAYNE, LOS ANGELES, MIAMI, NEW YORK, NEWARK, OAKLAND, PHILADELPHIA, PHOENIX, SAN FRANCISCO, TACOMA, AND WASHINGTON, D.C. WE CHOSE THESE SITES TO GET A PERSPECTIVE ON HOW CITIES OF VARYING SIZE AND LOCATION ARE AFFECTED BY CRACK BABIES.

ON MARCH 5, 1990, THE INSPECTOR GENERAL RELEASED THE DRAFT OF THIS REPORT TO OUR DEPARTMENT. WITH YOUR PERMISSION, WE WOULD ALSO LIKE TO MAKE THE REPORT PART OF THE RECORD OF TODAY'S HEARING.

FINDINGS

NOW I WOULD LIKE TO DISCUSS WHAT OUR STUDY FOUND. I WANT TO STRESS THAT OUR FINDINGS ARE BASED ON THE 12 SITES WE VISITED.

1. WE'RE ONLY SEEING PART OF THE CRACK BABY PROBLEM.

ONLY EIGHT OF THE CITIES WE VISITED COULD TELL US THE NUMBER OF BABIES REPORTED TO CHILD WELFARE. THESE EIGHT CITIES HANDLED 8,974 CRACK BABIES DURING THE PREVIOUS YEAR. THESE CITIES ACCOUNT FOR 17 PERCENT OF THE POPULATION OF U.S. CITIES OF MORE THAN 100,000 PEOPLE. SINCE WE BELIEVE THAT AS FEW AS HALF OF THE CRACK BABIES ARE ACTUALLY REPORTED TO CHILD WELFARE, IT IS REASONABLE TO ESTIMATE, AS CONTAINED IN THE PRESIDENT'S NATIONAL DRUG CONTROL STRATEGY REPORT, THAT AS MANY AS 100,000 COCAINE BABIES ARE BORN EVERY YEAR.

WE ESTIMATE THE COST OF HOSPITAL DELIVERY AND PERINATAL CARE, AND FOSTER CARE FOR THE 8,974 IDENTIFIED BABIES WILL APPROXIMATE $500 MILLION FOR THEIR FIRST FIVE YEARS OF LIFE.

SOME CRACK BABIES WILL ALSO NEED OTHER SERVICES. THE FLORIDA DEPARTMENT OF HUMAN RESOURCES HAS ESTIMATED A YEARLY COST OF OVER $40,000 PER CHILD TO GET CRACK BABIES READY FOR SCHOOL. IF THE OTHER STATES IN OUR STUDY WERE TO PROVIDE SIMILAR SERVICES FOR THE 8,974 IDENTIFIED BABIES, THE ADDITIONAL COSTS FOR THESE DEVELOPMENTAL INTERVENTION, EDUCATION, AND HEALTH SERVICES COULD EXCEED $1.5 BILLION FOR THE FIRST FIVE YEARS OF THESE BABIES LIVES.

THESE ESTIMATES DON'T INCLUDE COSTS FOR ANY OTHER SERVICES WHICH MIGHT BE NEEDED AFTER AGE 5, BUT SUCH COSTS COULD BE SUBSTANTIAL. IN THE STATE OF PENNSYLVANIA, FOR EXAMPLE, ONE YEAR OF SPECIAL EDUCATION IN A CLASS FOR A LEARNING DISABLED CHILD COSTS $7,900. A YEAR OF RESIDENTIAL TREATMENT AND SPECIAL EDUCATION FOR AN EMOTIONALLY DISTURBED CHILD COSTS BETWEEN $25,000 AND $47,500. THE AVERAGE EPISODE OF JUVENILE DETENTION LASTS 15 DAYS AND COSTS ABOUT $2,250. AND ONE ROUND OF RESIDENTIAL DRUG TREATMENT FOR A TEENAGER COULD COST $15,000 OR MORE.

WE FOUND THAT THERE IS NO "TYPICAL" CRACK BABY. ABOUT 70 PERCENT LOOK HEALTHY AND MOST ARE NOT IDENTIFIED AT BIRTH. MANY RESPONDENTS ARE CONCERNED THAT THE EFFECTS OF COCAINE EXPOSURE MAY NOT APPEAR UNTIL THE AGE OF 2 OR 3. THEY SAY THIS IS WHEN THE CHILDREN BEGIN TO DISPLAY DEVELOPMENTAL, NEUROLOGICAL, AND EMOTIONAL PROBLEMS.

MOST HOSPITALS DON'T TEST NEWBORN BABIES OR THEIR MOTHERS FOR DRUGS. THIS IS ESPECIALLY TRUE IN PRIVATE AND SUBURBAN HOSPITALS WHERE INFORMATION ON CRACK BABIES IS ALMOST NON-EXISTANT. INSTEAD, THEY RELY ON THE MOTHERS TO SELF-REPORT THEIR DRUG USE. HOWEVER, MANY MOTHERS DON'T ADMIT USING DRUGS. A SURVEY IN ONE FLORIDA HOSPITAL FOUND THAT ONLY 27 PERCENT OF THE PREGNANT WOMEN WHO TESTED POSITIVE FOR DRUG USE DURING DELIVERY HAD ADMITTED THEIR USE.

EVEN WHEN TESTS ARE DONE, THEY PROVIDE ONLY LIMITED INFORMATION. THIS IS BECAUSE MOST TESTS CAN ONLY DETECT COCAINE IN THE MOTHER FOR 24 TO 48 HOURS AFTER USE.

ACCORDING TO EXPERTS, CRACK BABIES ARE 4 TIMES MORE LIKELY TO BE BORN PREMATURE THAN BABIES NOT EXPOSED TO DRUGS IN UTERO. SOME WILL REQUIRE SPECIAL MEDICAL ATTENTION AT BIRTH AND AFTER HOSPITAL DISCHARGE.

WHAT'S AHEAD FOR CRACK BABIES? OUR RESPONDENTS WORRY THAT MANY WILL HAVE SEVERE LEARNING DISABILITIES AND WILL NEED SPECIAL EDUCATION. WE FOUND THAT THE LOS ANGELES UNIFIED SCHOOL DISTRICT HAS ALREADY DEVELOPED A SPECIAL CURRICULUM FOR CRACK BABIES IN PRESCHOOL, AND OTHER SCHOOL DISTRICTS ARE CONSIDERING DOING THE SAME THING.

2. THE CHILD WELFARE SYSTEM IS STRUGGLING TO COPE.

ACCORDING TO OUR RESPONDENTS, THE NUMBER OF DRUG ABUSE CASES IS GOING UP. IN NEW YORK CITY, CHILD ABUSE CASES DUE TO DRUG DEPENDENCY WENT UP 72 PERCENT FROM 1985 TO 1988.

CRACK BABY CASES ARE COMPLICATED AND TIME-CONSUMING. STATE OFFICIALS TOLD US THAT CRACK USERS REPRESENT A DIFFERENT KIND

OF PROTECTIVE SERVICES CASE THAN THEY ARE USED TO -- THERE IS A LOT MORE ABANDONMENT AND VIOLENCE.

MOST CRACK MOTHERS ARE NOT TEENAGERS. THEIR AVERAGE AGE IS 25 TO 28 YEARS, AND MANY ARE IN THEIR EARLY 30s. USUALLY, THEY HAVE 2 TO 4 OTHER CHILDREN. CRACK BABIES REPORTED TO THE CHILD WELFARE SYSTEM ARE PRIMARILY BLACK, WITH A SMALLER NUMBER OF HISPANICS AND EVEN FEWER WHITES.

CASEWORKERS CAN SPEND DAYS TRACKING DOWN MOTHERS WHO GIVE FALSE ADDRESSES TO HOSPITALS AND THEN ABANDON THEIR BABIES. THEY ALSO SPEND TIME FINDING EMERGENCY PLACEMENTS, FOSTER CARE, DRUG TREATMENT FOR THE MOTHERS, AND OTHER SPECIAL SERVICES.

PRENATAL EXPOSURE TO DRUGS IS OFTEN NOT TREATED AS CHILD ABUSE. BABIES WHO TEST POSITIVE FOR DRUGS ARE NOT ALWAYS REPORTED TO CHILD WELFARE OFFICIALS. THE ACTIONS DEPEND ON HOW A STATE DEFINES CHILD ABUSE OR NEGLECT. THESE DEFINITIONS VARY FROM STATE TO STATE.

THREE OF THE STATES WE VISITED REQUIRE HOSPITALS TO REPORT A POSITIVE DRUG TEST TO CHILD WELFARE OR A CENTRAL STATE REGISTRY. SOME HOSPITALS IN OTHER SITES MAKE VOLUNTARY REFERRALS. AT ONE SITE, HOSPITALS WERE INSTRUCTED TO REPORT CASES ONLY WHEN THE MOTHER CANNOT CARE FOR HER CHILD. IN TWO

OTHER CITIES, DRUG-EXPOSURE CASES ARE INVESTIGATED ONLY IF OTHER FACTORS ARE PRESENT, SUCH AS PRIOR ABUSE REPORTS.

THE GOOD NEWS IS THAT SEVERAL CHILD WELFARE AGENCIES ARE USING NEW APPROACHES TO DEAL WITH CRACK BABY CASES. SEVERAL CITIES HAVE SET UP HIGH-RISK DRUG BABY UNITS. CASEWORKERS IN THESE UNITS ARE SPECIALLY TRAINED TO HANDLE THE NEEDS OF CRACK BABIES AND THEIR MOTHERS. IN ONE CITY VISITED, THE CASEWORKERS IN THESE UNITS HAVE REDUCED CASELOADS.

ONE CHILD WELFARE AGENCY HAS DECENTRALIZED SERVICES TO THE COMMUNITY LEVEL. WORKING RIGHT IN THE NEIGHBORHOOD THEY SERVE ENABLES CASEWORKERS TO BECOME MORE FAMILIAR WITH LOCAL SERVICES AND PROVIDE BETTER SUPPORT FOR FAMILIES. CHILD WELFARE AGENCIES IN OTHER CITIES ARE ALSO CONSIDERING THIS APPROACH.

SOME CITIES ARE GIVING THEIR CASEWORKERS MORE TRAINING. LAST YEAR, NEW YORK CITY ALONE TRAINED OVER 1,200 NEW CASEWORKERS. MANY RESPONDENTS TOLD US THAT CHILD WELFARE CASEWORKERS NEED SPECIAL TRAINING TO IDENTIFY SUBSTANCE ABUSERS AND THEIR CHILDREN AND TO ASSESS THEIR SERVICE NEEDS.

THESE ARE JUST A FEW OF THE NEW APPROACHES WE FOUND. WE ARE NOW PREPARING A REPORT ON THESE AND OTHER PRACTICES FOUND TO BE EFFECTIVE IN DEALING WITH CRACK BABIES AND THEIR MOTHERS. WE PLAN TO ISSUE THIS COMPANION REPORT IN THE NEAR FUTURE.

IN SOME CITIES, HOSPITALS ARE PERFORMING TRADITIONAL CHILD WELFARE FUNCTIONS. THESE HOSPITALS RECRUIT FOSTER PARENTS AND MAKE PLACEMENT RECOMMENDATIONS TO CHILD WELFARE. THEY ALSO FIND, PROVIDE, AND COORDINATE A WIDE RANGE OF SERVICES FOR CRACK MOTHERS AND BABIES.

LACK OF COORDINATION IS THE MOST DIFFICULT PROBLEM THEY FACE IN PROVIDING SERVICES, ACCORDING TO MANY RESPONDENTS. SOME STATES ARE TACKLING THIS ISSUE. IN ILLINOIS, FOR EXAMPLE, CHILD WELFARE, ALCOHOLISM AND SUBSTANCE ABUSE, AND RELATED PROGRAMS NOW COLLABORATE TO PROVIDE COMPREHENSIVE SERVICES TO CRACK MOTHERS AND BABIES.

IN MIAMI AND FORT WAYNE, FAMILY COURTS AND CHILD WELFARE AGENCIES WORK TOGETHER TO MOVE CASES THROUGH THE SYSTEM FASTER. THEY CALL THIS PROCESS "FAST TRACKING." IT ENABLES THEM TO EXPEDITE THEIR PLACEMENT DECISIONS.

MANY SITES HAVE TASK FORCES TO ADDRESS THE CRACK BABY PROBLEM. STATE ATTORNEYS GENERAL, GOVERNORS AND MAYORS HAVE CREATED TASKS FORCES STAFFED BY PRIVATE CITIZENS, GOVERNMENT OFFICIALS, AND MEDICAL AND CHILD DEVELOPMENT EXPERTS. THEY IDENTIFY AND PULL TOGETHER SERVICE PROVIDERS, RECOMMEND POLICIES, AND INTEGRATE MONIES FOR SERVICES TO HIGH RISK FAMILES.

COMPREHENSIVE CASE MANAGEMENT IS ESSENTIAL TO HELP CRACK MOTHERS AND BABIES, ACCORDING TO OUR RESPONDENTS. CASE MANAGEMENT CONSISTS OF GUIDING FAMILIES TO A WIDE RANGE OF SERVICES, SUCH AS HEALTH CARE, EDUCATION, COUNSELING, DRUG REHABILITATION, AND PARENTING CLASSES. RESPONDENTS SAY THAT CRACK ADDICTS' PROBLEMS ARE SO COMPLEX AND THEIR ADDICTION SO OVERWHELMING THAT PROFESSIONAL CASE MANAGEMENT IS ESSENTIAL. IT'S JUST NOT REASONABLE TO EXPECT THEM TO SEEK OUT SERVICES THEMSELVES.

3. MOST BABIES GO HOME WITH THEIR MOTHER OR GRANDMOTHER, AND MANY GO INTO FOSTER CARE.

APPROXIMATELY 50-75 PERCENT OF IDENTIFIED CRACK BABIES GO HOME WITH THEIR MOTHER OR ANOTHER RELATIVE, USUALLY THEIR MATERNAL GRANDMOTHER. IN SOME CITIES, SUCH AS N.Y., RELATIVES CAN RECEIVE FOSTER CARE STATUS. OPINIONS ON THIS APPROACH VARY. WHILE SOME BELIEVE HAVING RELATIVES AS FOSTER PARENTS IS A GOOD IDEA, OTHERS SAY IT CAN DELAY REUNIFICATION OF MOTHER AND BABY, PIT ONE FAMILY MEMBER AGAINST ANOTHER, AND PERPETUATE THE BABY'S FOSTER CARE STATUS.

MOST OFFICIALS IN OUR STUDY ESTIMATE THAT 30-50 PERCENT OF IDENTIFIED CRACK BABIES GO INTO FOSTER CARE. BUT ACCORDING TO SOME OFFICIALS, MANY CHILDREN ARE LEFT WITH THEIR NATURAL PARENTS BECAUSE NO FOSTER PLACEMENTS ARE AVAILABLE. OFFICIALS

IN CHICAGO, NEWARK, AND WASHINGTON, D.C. REPORT CRITICAL FOSTER CARE SHORTAGE; OTHER CITIES IN OUR STUDY ARE COPING.

THE TOTAL NUMBER OF CHILDREN WHO NEED FOSTER PLACEMENT IS INCREASING. IN 1982, 262,000 NEEDED PLACEMENT. BY 1989, THE NUMBER ROSE TO 360,000. TO DEAL WITH THE DEMAND, SOME AGENCIES PUT MORE CHILDREN IN EACH FOSTER HOME, SHIFT CHILDREN BETWEEN HOMES, SEPARATE SIBLINGS, AND PLACE CHILDREN IN GROUP HOMES.

BLACK FOSTER PARENTS AND HOMES THAT ACCEPT INFANTS ARE IN SHORT SUPPLY. RESPONDENTS IN FOUR CITIES REPORT A PARTICULAR SHORTAGE OF HOMES FOR INFANTS WITH SPECIAL NEEDS. IN ONE STATE THAT PROHIBITS INTERRACIAL PLACEMENT, THE BABIES ARE PREDOMINANTLY BLACK, BUT WE WERE TOLD THERE IS A SHORTAGE OF BLACK FOSTER PARENTS.

LOW REIMBURSEMENT IS ONE REASON FOR THE FOSTER PARENT SHORTAGE. RESPONDENTS SAY REIMBURSEMENTS ARE TOO LOW TO ATTRACT FULL-TIME FOSTER PARENTS, ESPECIALLY FOR BABIES WITH SPECIAL MEDICAL NEEDS. REIMBURSEMENT RATE SCHEDULES ARE COMPLEX AND LACK UNIFORMITY. ONE CITY VISITED HAS 12 DIFFERENT PAYMENT CATEGORIES, RANGING FROM $3,233 TO $30,730 PER YEAR.

RESPONDENTS ALSO SUGGEST FOSTER PARENTS NEED TRAINING AND SUPPORT SERVICES, SUCH AS DAY CARE, TRANSPORTATION, RESPITE,

AND BETTER ACCESS TO HEALTH AND MENTAL HEALTH SERVICES FOR THEIR FOSTER CHILDREN.

NEWS ACCOUNTS FROM MANY CITIES REPORT GOOD RESULTS FROM OUTREACH EFFORTS SUCH AS NEWSPAPER STORIES, RADIO AND TV TALK SHOWS, AND PAID ADVERTISING. BUT WHILE THESE EFFORTS OFTEN RESULT IN AN OUTPOURING OF COMMUNITY RESPONSE, THE NUMBER WHO ACTUALLY GO ON TO BECOME FOSTER PARENTS IS LOWER, BECAUSE SOME APPLICANTS ARE DISQUALIFIED AND OTHERS LOSE INTEREST. RESTRICTIONS ON INTERRACIAL PLACEMENTS AND REQUIRING FOSTER PARENTS TO LIVE WITHIN CERTAIN GEOGRAPHIC LIMITS HAVE ALSO REDUCED THE POOL OF FOSTER PARENTS.

ON THE OTHER HAND, EVEN WITH SCREENING, SOME RESPONDENTS FEEL THE QUALIFICATIONS OF FOSTER PARENTS HAVE DECLINED. IN SOME PLACES, APPLICANTS WITH "MARGINAL" QUALIFICATIONS WHO WOULD HAVE BEEN TURNED AWAY A FEW YEARS AGO ARE NOW BEING ACCEPTED.

SOME GO TO OTHER SETTINGS

ALTHOUGH THE VAST MAJORITY OF CRACK BABIES GO HOME WITH MOTHER OR ARE PLACED IN FOSTER CARE, SOME MUST GO INTO EMERGENCY OR CONGREGATE CARE. EMERGENCY CARE IS A TEMPORARY PLACEMENT, USUALLY 30-90 DAYS, IN A SMALL GROUP HOME, A LARGE SHELTER, OR WITH A FOSTER FAMILY. IT IS INTENDED TO FILL THE GAP JUST UNTIL THE BABY GOES HOME WITH A PARENT OR IS PLACED IN FOSTER

CARE. BUT IF A LONG-TERM PLACEMENT CAN'T BE MADE WITHIN THE TIME LIMIT, A CASEWORKER MAY BE FORCED TO MOVE THE BABY FROM ONE EMERGENCY PLACEMENT TO ANOTHER.

CONGREGATE CARE IS A PERMANENT GROUP HOME, AND IT'S USUALLY FOR OLDER CHILDREN. BUT A FEW CRACK BABIES HAVE BEEN PLACED IN THIS TYPE OF SETTING. WE ENCOUNTERED STRONG OPINIONS ABOUT CONGREGATE CARE. SOME RESPONDENTS BELIEVE IT CAN WORK AS A SUBSTITUTE FOR FOSTER CARE AS LONG AS THE HOMES ARE SMALL, KEEP SIBLINGS TOGETHER, AND HAVE PROFESSIONAL STAFF. OTHERS, HOWEVER, THINK IT'S A BAD IDEA.

A FEW BABIES GO WITH THEIR MOTHERS TO RESIDENTIAL DRUG TREATMENT CENTERS. THEY STAY AT THESE CENTERS FROM 6 MONTHS TO 2 YEARS, DEPENDING ON THEIR TREATMENT NEEDS. SEVEN CITIES VISITED HAVE AT LEAST ONE OF THESE CENTERS, AND RESPONDENTS SAY MANY MORE ARE NEEDED.

SOME BABIES STAY IN THE HOSPITAL EVEN THOUGH THEY ARE MEDICALLY READY FOR DISCHARGE. KNOWN AS "BOARDER BABIES," THESE INFANTS FACE LEGAL COMPLICATIONS, QUESTIONS ABOUT PARENTS' ABILITY TO TAKE CARE OF THEM, OR LACK OF PLACEMENT ALTERNATIVES. BUT ABOUT HALF OF THE SITES VISITED NEVER HAD A BOARDER BABY PROBLEM. ONE-QUARTER HAVE MADE TIMELY PLACEMENTS, AND THE REMAINDER REPORT A SEVERE PROBLEM. WE ARE PREPARING A

COMPANION REPORT ON BOARDER BABIES WHICH WILL BE RELEASED SHORTLY.

FEW HAVE BEEN ADOPTED.

ONLY A FEW CRACK BABIES HAVE BEEN ADOPTED. THE ADOPTION PROCESS IS LONG, DIFFICULT, AND EXPENSIVE. PROSPECTIVE PARENTS CAN BECOME FRUSTRATED AND GIVE UP. MOST PROSPECTIVE PARENTS WANT BABIES. BUT OFFICIALS TELL US THAT TERMINATION OF PARENTAL RIGHTS IS USUALLY CONTESTED, AND THE PROCESS TAKES OVER 3 YEARS. BY THEN, MANY CHILDREN ARE TOO OLD TO BE ADOPTED.

RESPONDENTS CITED OTHER HINDRANCES TO ADOPTION. ONE EXAMPLE MENTIONED IS A LAW WHICH REQUIRES A 72-HOUR WAITING PERIOD WHEN THE MOTHER DECIDES TO VOLUNTARILY RELINQUISH PARENTAL RIGHTS. THIS CAN BE A PROBLEM BECAUSE ONCE A CRACK MOTHER LEAVES THE HOSPITAL, SHE SOMETIMES CAN'T BE FOUND AGAIN.

ANOTHER BARRIER TO ADOPTION IS THE BIAS AGAINST INTERRACIAL PLACEMENT. SOME RESPONDENTS SAY WHITE FAMILIES DON'T WANT BLACK BABIES; OTHERS SAY STATE AND LOCAL CHILD WELFARE AGENCIES ARE SLOW TO APPROVE INTERRACIAL ADOPTIONS.

MANY RESPONDENTS SAY THE EXISTING POLICY GOAL OF FAMILY REUNIFICATION IS UNREALISTIC FOR SOME CRACK BABIES AND SIMPLY

PROLONGS THE ADOPTION PROCESS. BUT OTHERS FEEL STRONGLY THAT THE CURRENT GOAL OF FAMILY REUNIFICATION SHOULD REMAIN.

MOST RESPONDENTS BELIEVE THAT EVEN IF PARENTAL RIGHTS WERE TERMINATED, MOST CRACK BABIES WOULD NOT BE ADOPTED. SOME CASEWORKERS FRANKLY SAY THERE ARE NOT ENOUGH PEOPLE WILLING TO ADOPT "THESE KIND OF CHILDREN." PROSPECTIVE PARENTS FEAR LONG TERM EFFECTS OF CRACK AND POTENTIALLY EXPENSIVE MEDICAL, EDUCATIONAL, OR PSYCHOLOGICAL NEEDS. SOME CITIES NOW PROVIDE ADOPTION SUBSIDIES FOR HARD TO PLACE CHILDREN AS ALLOWED UNDER FEDERAL LAW.

4. PEOPLE ARE WORRIED ABOUT PRENATAL EXPOSURE TO ALL DRUGS, NOT JUST CRACK.

RESPONDENTS REPEATEDLY TOLD US THAT IT MAKES NO SENSE TO SEPARATE CRACK FROM OTHER DRUGS, ESPECIALLY IN DEALING WITH THE EFFECTS OF PRENATAL EXPOSURE. THEY POINT OUT THAT MANY CRACK MOTHERS, ESPECIALLY ON THE EAST COAST, ALSO HAVE AIDS. THEY ALSO MENTION OTHER NEW DRUGS, SUCH AS "ICE," A METHAMPHETIMINE DERIVATIVE KNOWN TO PRODUCE RAPID, EXTENSIVE FETAL DAMAGE. IN FACT, THEY SAY THAT CRACK ADDICTS USE SO MANY OTHER DRUGS AND ALCOHOL THAT IT'S FUTILE TO TARGET JUST CRACK.

ALTHOUGH THERE IS NO CLEAR CONSENSUS ON EXACTLY WHAT TO DO, RESPONDENTS EXPRESSED A SENSE OF URGENCY TO DO SOMETHING. THEY

REPEATEDLY CALLED FOR STRONG FEDERAL LEADERSHIP, ACCURATE INFORMATION, AND HEIGHTENED PUBLIC AWARENESS. MANY SUGGESTED THAT A NATIONAL COMMISSION ON PRENATAL DRUG EXPOSURE COULD RAISE AWARENESS AND EDUCATE THE PUBLIC ABOUT PREVENTION.

RECOMMENDATIONS

WE AGREE WITH RESPONDENTS THAT THE PROBLEMS OF CRACK BABIES ARE INSEPARABLE FROM THE LARGER ISSUE OF PRENATAL EXPOSURE TO ALL DRUGS AND ALCOHOL. OUR RECOMMENDATIONS, FOR STATE AND LOCAL, AS WELL AS THE FEDERAL GOVERNMENT, ARE INTENDED TO ADDRESS THIS BROADER ISSUE.

STATE AND LOCAL RESPONSIBILITIES

1. STATE AND LOCAL GOVERNMENTS SHOULD CONDUCT AGGRESSIVE OUTREACH PROGRAMS TO IDENTIFY AT-RISK PREGNANT WOMEN AND GET THEM INTO PRENATAL CARE. THESE PROGRAMS SHOULD USE LOCAL COMMUNITY AND RELIGIOUS LEADERS TO IDENTIFY POTENTIAL CLIENTS AND ENCOURAGE THEM TO PARTICIPATE.

2. STATE AND LOCAL GOVERNMENTS SHOULD REDUCE BARRIERS TO FOSTER CARE AND ADOPTIVE PLACEMENTS. THIS WOULD INVOLVE REVIEWING AND REVISING EXISTING LAWS AND POLICIES ON ABANDONMENT, TERMINATION OF PARENTAL RIGHTS, AND

INTERRACIAL PLACEMENT. COURTS SHOULD ESTABLISH PROCEDURES TO EXPEDITE CHILD WELFARE CASES INVOLVING DRUG ABUSE.

3. STATE AND LOCAL GOVERNMENTS SHOULD DEVELOP GUIDELINES AND TRAIN CASEWORKERS. THE GUIDELINES SHOULD COVER RISK ASSESSMENT, FAMILY REUNIFICATION, AND TERMINATION OF PARENTAL RIGHTS. CASEWORKERS SHOULD BE TRAINED TO IDENTIFY SUBSTANCE ABUSE BEHAVIORS, RECORD DRUG HISTORIES, AND DOCUMENT EVIDENCE FOR COURT.

FEDERAL RESPONSIBILITIES

1. THE DEPARTMENT OF HEALTH AND HUMAN SERVICES SHOULD CONDUCT LONG-TERM RESEARCH ON THE EFFECTS OF PRENATAL EXPOSURE TO DRUGS ON BABIES AND THEIR MOTHER. AREAS WHERE RESEARCH SHOULD BE CONDUCTED INCLUDE THE LONG-TERM EFFECTS OF PRENATAL DRUG EXPOSURE ON PHYSICAL, PSYCHOLOGICAL AND NEUROLOGICAL DEVELOPMENT; LONG-TERM OUTCOMES OF VARIOUS TREATMENT APPROACHES FOR WOMEN OF CHILD-BEARING AGE; AND RESULTS OF PERMANENT PLACEMENT OPTIONS.

2. THE DEPARTMENT OF HEALTH AND HUMAN SERVICES SHOULD PROMOTE DRUG ABUSE TRAINING IN MEDICAL SCHOOLS AND CHILD WELFARE AGENCIES. MOST PHYSICIANS ARE NOT TRAINED TO RECOGNIZE THE SIGNS OF DRUG USE. AS A RESULT, THEY FAIL TO IDENTIFY MANY PREGNANT WOMEN WHO ARE USING DRUGS AS WELL AS

NEWBORNS EXPOSED IN UTERO. MEDICAL SCHOOL CURRICULA SHOULD BE REVISED TO INCLUDE TRAINING ON HOW TO RECOGNIZE AND TREAT DRUG ABUSE.

HHS SHOULD ASSIST STATE AND LOCAL CHILD WELFARE AGENCIES BY DEVELOPING AND DISSEMINATING MODEL TRAINING MATERIALS FOR CHILD WELFARE AGENCIES.

3. THE DEPARTMENT OF HEALTH AND HUMAN SERVICES SHOULD CONTINUE TO SUPPORT PRENATAL CARE EXPANSION AND PROMOTE PREVENTION THROUGH PUBLIC OUTREACH AND INFORMATIONAL MATERIALS. EXISTING ANTI-DRUG MESSAGES DO NOT EMPHASIZE THE DANGERS OF PRENATAL DRUG EXPOSURE. A COMPREHENSIVE STRATEGY SHOULD BE DEVELOPED TO TARGET WOMEN OF CHILD-BEARING AGE. THIS EFFORT SHOULD BE COUPLED WITH EXPANDED AVAILABILITY OF PRENATAL CARE FOR AT-RISK MOTHERS AND THEIR BABIES.

THIS CONCLUDES MY TESTIMONY. I AM AVAILABLE TO ANSWER YOUR QUESTIONS.

DRAFT

CRACK BABIES

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EXECUTIVE SUMMARY

PURPOSE

This report examines how crack babies are affecting the child welfare system in several major cities.

BACKGROUND

Crack is cocaine in a smokeable form. The National Institute on Drug Abuse (NIDA) estimates that over 5 million women of child bearing age are using illegal substances; for 1 million this means cocaine. The President's National Drug Control Strategy report estimates that 100,000 cocaine exposed babies are born each year.

Prenatal cocaine exposure can lead to premature birth, low birthweight, birth defects, and respiratory and neurological problems. Crack babies have a significantly higher rate of Sudden Infant Death Syndrome (SIDS) than babies not prenatally drug exposed. While experts believe that many crack babies will suffer developmental disabilities, the full range of long term effects of prenatal cocaine exposure are not known.

When crack babies are identified, local child welfare agencies are usually notified to provide protective services, social services, or foster care. However, these agencies are often unable to meet the needs of crack babies and their mothers.

While some State and local governments have done studies on aspects of the crack baby problem, little data is currently available at the national level. Several studies are underway at the Federal level to gain insight into this problem.

METHODOLOGY

We conducted on-site interviews in 12 metropolitan areas during the last quarter of 1989. Respondents included child welfare administrators and caseworkers, hospital social services staff, private agency representatives, foster parents, State and local officials, and national experts.

We also reviewed numerous studies and public documents on this subject.

FINDINGS

We're Only Seeing Part Of The Problem.

- Eight cities identified 8,974 crack baby cases in 1989; the cost of hospital delivery and perinatal care, and foster care through age 5 could approximate $500 million.

- There is no typical crack baby. Most are not identified at birth.
- Many are born premature; some have special medical needs and others require "high tech" care.
- Crack babies face future problems.

The Child Welfare System Struggles To Cope.

- Crack baby cases are complicated and time-consuming.
- Prenatal drug exposure is not usually treated as child abuse.
- Several child welfare agencies are using new approaches to deal with crack baby cases.
- Hospitals are beginning to perform child welfare functions in some cities.
- Comprehensive case management is essential in helping crack addicted mothers and their babies.

Most Crack Babies Go Home, But Many Go Into Foster Care.

- About 50 to 75 percent of babies go home with mother or a relative.
- Up to 50 percent go into foster care.
- Some go to emergency placements or group homes.
- Few crack babies have been adopted.

People Are Worried About The Effects Of Prenatal Exposure To All Drugs, Not Just Crack.

- Crack isn't all that threatens the lives of crack mothers and their babies.
- Respondents want leadership and action.

RECOMMENDATIONS

State And Local Governments Should:

- Encourage outreach and community involvement with aggressive campaigns emphasizing the dangers of prenatal drug and alcohol exposure.
- Reduce placement barriers by reviewing and revising existing laws and policies on abandonment, termination of parental rights, and interracial placement.
- Develop guidelines and training for child welfare staff.
- Establish reporting and tracking systems.
- Expand interagency mechanisms to coordinate services and integrate funding.

The Office Of Human Development Services Should:

- Identify and disseminate practices considered effective in drug exposed baby cases.
- Focus service strategies on serving the entire family.
- Evaluate obstacles to foster care and adoptive placements and develop strategies for overcoming them.
- Coordinate Departmental activities through an interagency workgroup.

The Office Of Human Development Services And The Public Health Service Should:

- Conduct long-term research on the effects of prenatal exposure, treatment models, and placement outcomes.
- Promote drug abuse training in medical schools and child welfare agencies.
- Promote prevention through public outreach and informational materials.

The Public Health Service And The Health Care Financing Administration Should:

- Continue to support prenatal care expansion.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

INTRODUCTION 1
- Purpose 1
- Background 1
- Methodology 2

FINDINGS 3
- We're only seeing part of the problem. 3
- The child welfare system struggles to cope. 6
- Where do babies go? 9
- People are worried about prenatal exposure to all drugs, not just crack. 13

RECOMMENDATIONS 14

ENDNOTES 17

INTRODUCTION

PURPOSE

This report examines how crack babies are affecting the child welfare system in several major cities. A separate report identifies programs and procedures considered effective in working with crack addicted mothers and their babies.

BACKGROUND

Crack is cocaine in a smokeable form. We use the terms crack and cocaine synonymously in this report as their detection in the body does not differ. Crack first appeared in the United States during the mid-1980's. The National Institute on Drug Abuse (NIDA) estimates that over 5 million women of child bearing age are using illegal substances; for 1 million this means cocaine. The President's National Drug Control Strategy estimates that 100,000 cocaine exposed babies are born each year.

Prenatal cocaine exposure can lead to premature birth, low birthweight, birth defects, and respiratory and neurological problems. Crack babies have a significantly higher rate of Sudden Infant Death Syndrome (SIDS) than babies who have not been prenatally drug exposed. The long term effects of prenatal cocaine exposure are not currently known.

Three Department of Health and Human Services agencies are directly affected by the increase in crack baby births: the Office of Human Development Services (HDS), the Public Health Service (PHS), and the Health Care Financing Administration (HCFA). These Federal agencies fund services for crack addicted mothers and their babies through a variety of programs which are largely operated at the State and local level.

When crack babies are identified, local child welfare agencies are usually notified to provide protective services, social services, or foster care. However, these agencies are often unable to meet the needs of crack babies and their mothers.

Most crack mothers are not teenagers. Most often, they are between their early 20s and 30s, with an average age of 25 to 28 years. Usually, they have between two and four other children. Crack babies reported to the child welfare system are primarily black, with a smaller number of Hispanics and even fewer whites.

While some State and local governments have done studies on this issue, little data is currently available at the national level. Both HDS and PHS have several studies underway to gain insight into the problem. The General Accounting Office (GAO) is also studying the costs of services for this population. In addition, the Office of Inspector General (OIG) is conducting two related inspections on the termination of parental rights and laws regarding prenatal exposure to substance abuse.

METHODOLOGY

We conducted on-site interviews with over 200 respondents in 12 metropolitan areas during the last quarter of 1989. The sites included: Chicago, Fort Wayne, Los Angeles, Miami, New York City, Newark, Oakland, Philadelphia, Phoenix, San Francisco, Tacoma, and Washington, D.C. We selected these sites to give a perspective on how cities of varying size and location were being affected by crack baby births.

Respondents included child welfare administrators and caseworkers, hospital social services staff, private agency representatives, foster parents, and State and local officials. We also interviewed a number of national experts.

We also reviewed numerous studies and public documents on this subject.

FINDINGS

WE'RE ONLY SEEING PART OF THE PROBLEM

The scope of the problem is wide ranging.

Only two-thirds of the cities we visited could provide the number of crack babies reported to the child welfare system. These eight cities handled 8,974 crack baby cases during the previous year. These cities represent 17 percent of the population of U.S. cities of more than 100,000. Many crack cases are unreported, with one respondent estimating that only half of the crack babies are reported in her city. The actual figures we obtained, coupled with the underreporting phenomenon, are consistent with President Bush's National Drug Control Strategy report which estimates 100,000 cocaine babies born per year.

We estimate the cost for hospital delivery and perinatal care, and foster care through age 5 for just these 8,974 identified babies approximate $500 million.

Crack babies may also require other services. The Florida Department of Human Resources estimates an annual cost of over $40,000 per child to get crack babies ready for school. If other States in our study were to provide similar services for these 8,974 identified babies, the additional costs for developmental intervention, education, and health services through age 5 could exceed $1.5 billion.

While these calculations do not include any costs for services which may be required by some crack-exposed children after age 5, such costs will also be substantial. In Pennsylvania, for example, one year of special education in a class for a learning disabled child costs $7,900. A year of residential treatment and special education for an emotionally disturbed child costs $25,000 to $47,500. The average episode of juvenile detention lasts 15 days and costs about $2,250. If a juvenile requires residential drug treatment, costs can be $15,000 or more.[1]

There is no typical crack baby. Most are not identified at birth.

Most crack babies look healthy. According to one national expert, an estimated 70 percent look healthy at birth.[2] This may be the reason many physicians don't detect the early symptoms of most crack babies. Our observations and interviews at hospitals and placement facilities also suggest that most crack babies appear healthy.

Many respondents were concerned that the effects of cocaine exposure may not appear until the age of 2 or 3. They say this is when the children begin to display developmental, neurological, and emotional problems.

Most respondents agree that large numbers of crack babies are not being identified. According to respondents, public hospitals are the only ones testing; private hospitals and physicians do not test. While no State visited mandates universal testing of mothers for

controlled substances, Indiana does require testing if there is suspicion of drug exposure. One hospital in our sample tests all newborns.

The vast majority of hospitals in our survey rely on mothers to self-report drug use. At least four use this as their primary method of identification. Some respondents criticize using this method exclusively. A survey in one Florida hospital found that only 27 percent of the pregnant women testing positive for drug use at labor and delivery had admitted their use.[3]

Only four hospitals visited use a specific testing protocol and these vary in detail and scope. Testing criteria include suspected drug use, lack of prenatal care, premature delivery, neonatal intensive care admission, and indications of a sexually transmitted disease.

Even when tests are conducted, they provide limited information. Most tests can detect cocaine in the mother for only 24 to 48 hours after use. In addition, cocaine test results are not always reported separately from other drugs.

Many crack babies are born prematurely; some have special medical needs and others require "high tech" care.

Experts report that crack babies are 4 times more likely to be born premature with low birth weights (under 2500 grams or about 5.5 pounds) than babies who are not exposed to drugs in utero.

Some crack babies require special medical attention after hospital discharge. These children are designated as medically needy and require special services from their mothers or foster care families.

In his April 1989 testimony before the U.S. House Select Committee on Children, Youth and Families, Dr. Neal Halfon estimated that 18 percent of crack babies require intensive care. Some respondents told us that modern technology allows physicians to save many babies who would not have survived even a few years ago. This is especially true of the very low birth weight babies (500 -1500 grams, about 1 to 3 pounds). Some babies remain in neonatal intensive care for long periods.

Crack babies face future problems.

When considering how society will deal with crack babies, some respondents emphasize that the environments in which these children are raised will play a major role in their development. In one expert's view, the real issue is "how much damage is actually attributed to post utero environment as opposed to in utero exposure to drugs."

Many respondents worry what will happen when crack babies reach school. Those who have worked with crack babies say the children will have severe learning disabilities, such as short attention spans, as they grow older. We were told, "These children need special education. If they don't get that, we'll see them in juvenile court later." The Los Angeles Unified School

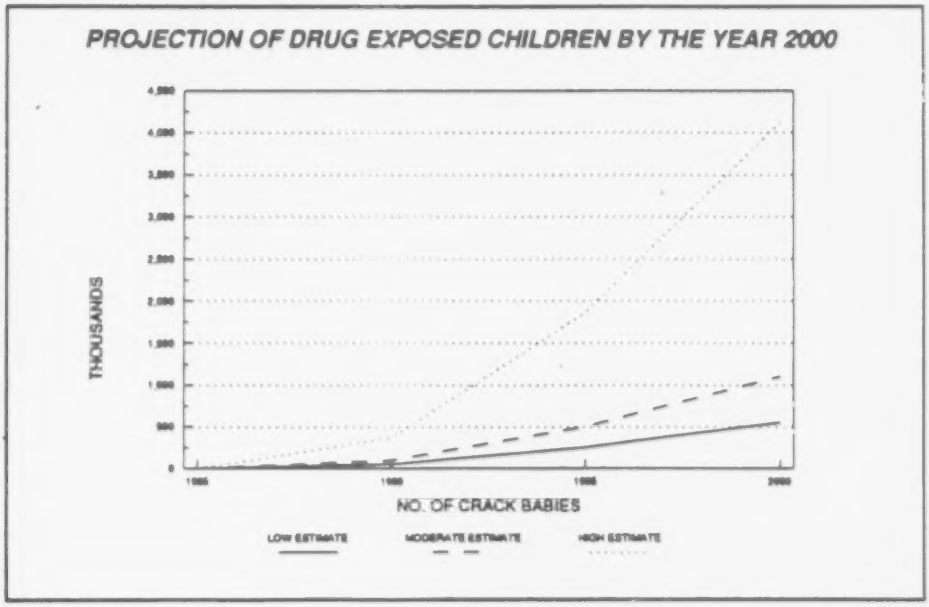
District has already developed a special curriculum for crack babies at the preschool level. Other districts are considering such initiatives.

Many children are staying in foster care longer. As recently as 1985, nationwide median foster care stays ranged from 9 months for those who had left foster care to 1.5 years for those who still remain. However, officials from two cities in our survey reported the current average length of stay as 3 years and 4.8 years respectively. Part of the reason children may be staying in foster care longer is that they are entering at a younger age. A recent New York State report stated, "In 1980, only 19 percent of the foster care caseload was under 5. Today it is over 50 percent, primarily due to crack."[4]

Babies placed in foster care bond with their foster mothers rather than their biological mothers. If moved from home to home, they may not bond with anyone. Foster care can also create a bonding problem for siblings. Respondents said that siblings who have not bonded have problems relating to one another when families are reunited. Siblings who have bonded and are then separated can become angry, hostile, and emotionally scarred.

Interviewees tell us the aftershocks of the crack epidemic will be felt by society for many years. As one respondent said, "Even if we stopped crack use right now, we would still be dealing with its effects in some way for the next 50 to 75 years. The ramifications are forever...it's a horrible cycle!"

By the end of this decade, the first crack babies will be entering their teens. The chart below illustrates how many crack exposed children there may be by the year 2000. The range of estimates shown is based on current data.



THE CHILD WELFARE SYSTEM STRUGGLES TO COPE.

Crack baby cases are complicated and time-consuming.

In most cities visited, an increasing majority of child welfare cases are drug related. The New York City mayor's task force reported a 72 percent increase in child abuse due to drug dependency, primarily crack, from 1985 to 1988.

State officials contend that crack baby cases are more complex than other child welfare cases. One official said, "Crack users represent a different kind of [protective services] case—there is a lot more abandonment and violence."

Drug use can supercede all other aspects of the lives of crack addicted mothers. In the words of one caseworker, working with the mothers "is like beating your head against a brick wall...because you are dealing with someone who has no control over her life. She's worried about her next hit."

Caseworkers can spend days tracking mothers who give false addresses to hospitals and then abandon their babies. Other time-consuming activities include finding emergency placements, foster care, parental drug treatment, and services necessary for special needs children.

Child welfare casework is a dangerous job, according to several respondents. Caseworker home evaluations can require entering hostile situations, unescorted and without radio contact. "Police don't go into some of these places," said one respondent. Personal danger, stress, and relatively low pay contribute to caseworker burnout or resignation. One city official reported half of the staff had been working less than 1 year. In another city, the average tenure of a child protective worker is 2 years.

Some child welfare officials point out that high turnover results in staff who lack long term experience or training. They say this problem creates a lack of continuity of service and complicates legal proceedings as several caseworkers may work on a case over the years.

We found large caseloads of child welfare workers in many cities. One typical child welfare agency official reported an average caseload of 49 children for foster care and 161 for protective services. The lowest reported caseload was in New York City with 20 children for family service caseworkers and 40 for protective services.[5]

Prenatal exposure to drugs is not treated as child abuse.

Babies who test positive for controlled substances are not always reported to child welfare officials. The actions taken depend on how a State defines child abuse or neglect. These terms are not interchangeable and the distinction can be significant.

Indiana law provides that any detection of prenatal exposure to drugs constitutes child abuse. In Fort Wayne, the baby and any siblings are to be placed in protective custody pending an investigation. Illinois adopted a similar definition on January 1, 1990.

Only four States visited require hospitals to report a positive toxicology to the child welfare agency or a central State registry. Some hospitals in other sites visited make referrals voluntarily. At one site, hospitals have been instructed by the child welfare agency to report cases only when the mother could not care for her child. Additionally, in at least two other cities, drug-exposure cases are investigated only if accompanied by other factors, such as mother self-identification or prior abuse reports.

Several child welfare agencies are using new approaches to deal with crack baby cases.

Several cities have organized high risk drug baby units to provide intake and risk assessment for drug-exposed infants. Caseworkers are specially trained to deal with the needs of the substance abusing mother and her child. In at least one city, the caseworkers in these units have reduced caseloads.

One child welfare agency has decentralized services into zones and community districts. Caseworkers are now physically closer to the families they serve. This enables caseworkers to provide better support for families and become more familiar with local services. Child welfare agencies in other cities are considering this concept.

Cities are providing more caseworker training; New York City trained 1,264 new caseworkers in 1989. Many respondents mentioned the need for more training of child welfare workers in identifying and assessing the needs of substance abusers and their children. Other respondents feel that caseworkers need formal guidelines for making parental termination decisions.

Hospitals are beginning to perform child welfare functions in some cities.

Many hospital officials told us that child welfare agencies are overwhelmed, so they are taking action. They say hospitals cannot afford the financial losses that extended stays create. In several cities, hospitals have begun to actively recruit foster parents, especially among their own staff. Some hospitals now make placement recommendations to child welfare.

Staff at several hospitals now locate, provide, and coordinate services for crack mothers and babies. Other hospitals have begun to conduct follow-up tracking. Hospital officials also have problems with staff turnover, morale and burnout. One hospital administrator referred to her neonatal intensive care ward as like "a M.A.S.H unit."

Interagency coordination helps child agencies welfare cope.

The lack of coordination is the most difficult problem faced in providing services to crack babies and their families, according to many respondents. One interviewee said, "Interagency case management is the key to addressing this issue, if anything works."

Some States and private agencies are tackling the issue of coordination. Illinois has a program of collaboration among child welfare, alcoholism and substance abuse, and related programs. State officials report that they "have reduced systems barriers to integrated services and allowed for a full complement of services to be made available to high risk families."[6]

Family court divisions and child welfare agencies in Miami and Fort Wayne coordinate services by "fast tracking" cases through the system. Fast tracking is a process where the courts agree to set aside specific times to expedite cases. Sites using this method report more and faster placement decisions.

Many sites have task forces to address the crack baby problem. In at least two States, Attorneys General were the impetus for the task forces. At other sites, three State governors and two mayors have created task forces. The task forces are staffed by private citizens, government officials, and medical and child development experts. They identify and pull together service providers, recommend policies, and integrate monies for services to high risk families.

Comprehensive case management is essential in helping crack-addicted mothers and their babies.

Case management consists of guiding families to services such as early intervention, education, health care, counseling, physical therapy, drug rehabilitation, and parenting classes. Respondents tell us that existing approaches which require clients to seek out supportive services do not work with crack addicts. Client needs are so complex and their addiction so overwhelming that professional case management is needed.

The case manager is an advocate who leads families through the system. In the words of one respondent, it is unrealistic to expect a crack-addicted mother to meet the "demands of 8 to 10 different service providers simultaneously." A case manager is seen as necessary to guide and motivate mothers and to supervise the care of the children. This is widely seen as the responsibility of the child welfare agency.

Successful case management requires readily accessible services, according to many respondents. They say crack addiction results in demanding, impatient behavior. Respondents often said that crack mothers will deny that they have a problem and refuse services.

Many respondents emphasize the need to locate services in the community and provide transportation and child care. Their most frequent comment was that central locations with multiple services work best; "one stop care," said one caseworker.

WHERE DO THE BABIES GO?

Most babies go home with their mother or a relative.

Although few statistics are kept, respondents offered personal insights into the demographics of crack baby families. Usually 50 to 75 percent of identified crack babies go home with their mother or a relative, although the range is 50 to 95 percent at the sites visited. At two sites, a baby is put into temporary protective custody (for up to 72 hours) while the child welfare agency investigates.

Maternal grandmothers are the relative most likely to take the baby. Most child welfare workers try to place a baby with the grandmother before making any other kind of placement. Respondents at five sites say grandmothers, who often take care of several children, are overwhelmed by the needs of drug-exposed babies. Officials report few fathers are involved with the custody of the baby.

Some relatives receive foster care reimbursements. Most child welfare agencies prefer relatives to foster placements, but relatives often cannot afford to take care of the babies. New York City provides State-approved relatives with foster care reimbursements, but opinions on this approach vary. While some believe this approach is fairer and results in better monitoring, others say such programs delay reunification of mother and baby, create family antagonism, and perpetuate the baby's foster care status. At least one respondent said it creates opportunities for fraud.

When mothers enter drug treatment centers that do not accept infants, their babies go to relatives or foster care. The restrictions against infants may be due to insurance liabilities and the traditional adult orientation of treatment programs. Some mothers must attend out-patient drug treatment programs as a condition for keeping their babies. Respondents tell us some mothers drop out of treatment or resume using drugs, but most treatment programs do not track recidivism among the mothers.

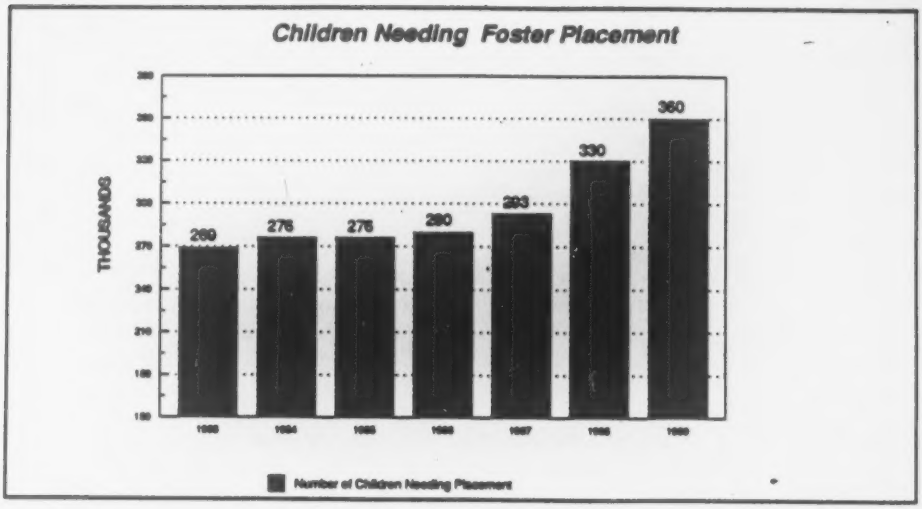
Many babies go into foster care.

Most officials estimated that 30 to 50 percent of identified crack babies go into foster care, although reports ranged from 5 to 50 percent. According to some officials, children are often left with their natural parents because no foster placements are available.

Officials in Chicago, Newark, and Washington, D.C. report critical foster care shortages; others are coping. Fort Wayne and Phoenix have little difficulty finding foster families; both have comparatively small numbers of drug-exposed babies.

As shown in the chart below, the number of children in need of foster placement is increasing. In 1982, there were 262,000 children needing placement; 280,000 in 1986; 330,000 in 1988 and an estimated 360,000 in 1989.

28-384 0 - 90 -3



Respondents speculated that the increase of children in foster care is due to increased parental drug abuse, but this cannot be confirmed. Data to demonstrate this connection is not collected nationwide by child welfare agencies.

Shortages of black foster parents and homes that accept infants are reported. Respondents in five cities report a particular shortage of homes for infants with special needs. In one State that prohibits interracial placements, we were told the babies are predominantly black, but there is a shortage of black foster parents. To deal with the demand, some agencies put more children in each foster home, shift children between homes, separate siblings, and place children in group homes.

Low reimbursement was the most commonly cited reason for a shortage of foster parents. Respondents say reimbursements are too low to attract full-time foster parents, especially for medically needy babies.

Also, rate schedules are complex and lack uniformity. Variables affecting rates include the child's age and health, the placement agency, and the services or products that qualify for reimbursement. For example, one city has eight categories of reimbursement for infants who do not require consistent medical attention. For infants who do require consistent medical care, there are four categories. Within each category, child welfare has the flexibility to determine the exact reimbursement rate. Overall, reimbursement ranges from $3,233 to $30,730 annually.

Respondents told us repeatedly that foster parents need training and support services. They said there is a correlation between such training and a foster parent's willingness to continue.

Others commented that foster parents need day care (regular and therapeutic), transportation, respite, and better access to physical and mental health services for their foster children.

News accounts from many cities report good results from outreach efforts. Strategies frequently incorporate newspaper stories, radio and TV talk shows, and paid advertising. Other recruitment strategies include teaming private foster care agencies with specific hospitals, offering bonuses to foster parents who recruit other foster parents, and working with local churches and community groups. Child welfare agencies and private agencies are also expanding the pool of potential foster parents by accepting singles, full-time employees, gay men, and lesbians.

Although these efforts often result in an outpouring of community response, the number who actually become foster parents is lower than the number who apply. Some applicants are disqualified while others lose interest. Respondents also say that there are obstacles to increasing the pool of foster parents and keeping them. These include requirements that foster parents live within certain geographic limits and restrictions on interracial placements.

Some respondents say that even with screening, the qualifications of foster parents have declined. According to a West Coast caseworker, applicants with "marginal" qualifications who would have been turned away a few years ago are now being accepted.

A few go to other care settings.

Crack babies are occasionally placed in other care arrangements, such as emergency care and congregate care. Emergency care is a temporary placement pending return to a parent or placement in foster care. Emergency care can be a small group home, a large shelter, or a foster family. When a long-term placement cannot be made, caseworkers may be forced to move babies from one emergency placement to another. Two cities reported that they need but do not have emergency placement facilities.

Congregate care is usually a permanent group home. While used mostly for older children, some babies have been placed in such care. Officials in one city received strong public criticism of the care provided to babies in congregate care. As a result, all babies originally placed in congregate care have been placed in foster homes. Washington, D.C. is now building two group homes for infants to cope with their critical foster care shortage.

We encountered strong opinions about congregate care. Of 58 respondents, nearly half (27) believe congregate care can work as a substitute for foster care as long as the homes are small, keep siblings together, and are managed professionally. Twenty-one respondents think congregate care is a bad idea; 10 have mixed opinions.

A few babies go with their mothers to residential drug treatment centers. They stay at these centers from 6 to 24 months, depending on their treatment needs. Seven cities visited have at least one such center, and respondents say many more are needed.

Some babies remain in the hospital even though medically ready for discharge. Known as "boarder babies," these infants face legal complications, questions about parents' ability to care for them, or lack of other care alternatives. Half of the sites visited have never had a boarder baby problem. One-quarter have made timely placements, and the remaining quarter report a severe problem. For more information on boarder babies, refer to our companion report, "Boarder Babies," OEI-03-89-01541.

Few crack babies have been adopted.

While respondents prefer adoption to permanent foster care, opinions on adoption verses family reunification differ widely. Many respondents said the existing policy goal of family reunification is unrealistic for many crack babies and simply prolongs the adoption process. But others feel strongly that the current goal of family reunification should remain.

The adoption process is long, difficult, and expensive. Prospective parents often become frustrated and give up. Most prospective parents want babies. Officials tell us that termination of parental rights is usually contested, and although the process can theoretically be completed in 18 months; in reality it takes at least 3 years. By then these older children are less likely to be adopted; they're not babies anymore.

One children's advocacy group stated that caseworkers guiding the process need to be more aggressive "to challenge the hurdles of the adoption process, to face a court which seems reluctant to approve adoption,...to [confront] the parent, and to negotiate the obstacles of the agency process itself."[7]

Respondents cited other hindrances to the adoption process. At least one respondent referred to a law which requires a 72-hour waiting period for a mother wishing to voluntarily relinquish parental rights. Also, caseworkers told us that once a crack mother leaves the hospital, she sometimes can't be found again.

Another long standing barrier to adoption is the bias against interracial placement. Some respondents say white families don't want black babies; others say States and agencies are the ones slow to approve interracial adoptions. Adoption by relatives is one way to deal with racial policies. But even relatives face long, intensive investigations.

Most respondents believe that even if parental rights were terminated, most crack babies would not be adopted. Some caseworkers frankly say there are not enough people willing to adopt "these kind of children." Prospective parents fear long term effects of crack and potentially expensive medical, educational, or psychological needs. Some cities now provide adoption subsidies for hard to place children as allowed under Federal law.

PEOPLE ARE WORRIED ABOUT PRENATAL EXPOSURE TO ALL DRUGS, NOT JUST CRACK.

Crack isn't the only threat to the lives of crack mothers and their babies.

On the West Coast, the next drug crisis is already here. Child welfare agencies are preparing for babies born to users of a methamphetamine derivative called "ice." Although ice is more expensive than crack, the high lasts much longer. Methamphetamine is known to produce rapid, extensive fetal damage.

Many respondents, especially on the East Coast, were concerned about the overlap of AIDS and crack. In the words of one official, "You can't separate the crack baby problem from the AIDS problem." Respondents said many crack abusing mothers engage in high risk behavior and bear AIDS infected babies. A health official said, "AIDS is now the largest killer among young women [here]. We may not have to worry about [crack baby] mothers; they'll all be dead."

Respondents want leadership and action.

Respondents repeatedly called for strong leadership, accurate information, and heightened public awareness. They point out that crack addicts use so many other drugs and alcohol that it's futile to target just crack. Although there is no clear consensus on exactly what to do, people express a sense of urgency. In the words of a private agency official, "It's time to fish or cut bait."

A foremost suggestion of respondents was to establish a national commission on prenatal drug exposure. Many respondents point to the success of the National AIDS Commission in raising awareness and educating the public about prevention. They urged the HHS Secretary to take this proposal to the President. These respondents see a national commission as a way to galvanize public attention, promote greater participation by State and local governments and the private sector, and generate potential solutions. It was suggested that this commission be drawn from the public and private sector, and include representatives from a wide variety of disciplines, such as education, health, child welfare, substance abuse, justice, and housing.

RECOMMENDATIONS

We agree with respondents that the problems of crack babies are inseparable from the larger issue of prenatal exposure to all drugs and alcohol. The recommendations that follow are intended to address this broader issue.

STATE AND LOCAL RESPONSIBILITIES

1. *Encourage outreach and community involvement.* State and local governments should conduct aggressive outreach programs to provide prenatal care for at risk pregnant women. These efforts must emphasize the dangers of prenatal drug or alcohol exposure. Community and religious groups should be involved in identifying and helping mothers and children at risk. It is important to work with local black and Hispanic leaders.

2. *Reduce placement barriers.* State and local agencies should reduce barriers to placing drug exposed infants into foster care and adoptive homes. This includes reviewing and revising existing laws and policies on abandonment, termination of parental rights, and interracial placement. Courts should establish "fast track" procedures to expedite child welfare cases involving drug abuse.

3. *Develop guidelines and training.* States should develop guidelines for child welfare agencies to follow in responding to drug exposure cases and training caseworkers to handle such cases. Guidelines should cover risk assessment, family reunification, and termination of parental rights. Caseworkers should be trained in identifying substance abuse behaviors, recording drug histories, and documenting evidence for court.

4. *Establish reporting and tracking systems.* States should establish criteria for reporting prenatal drug exposure as child abuse. Existing State child abuse reporting and tracking systems should be expanded and computerized.

5. *Expand interagency mechanisms.* State and local governments should develop initiatives such as task forces to coordinate services and integrate funds. These initiatives should involve courts and prosecutors to review policies and expedite legal proceedings involving drug-exposed babies and their families.

DEPARTMENT OF HEALTH AND HUMAN SERVICES RESPONSIBILITIES

Office of Human Development Services

1. *Disseminate effective practices.* The Office of Human Development Services (HDS) should identify practices, programs, and laws or regulations considered effective in dealing with drug-exposed baby cases and disseminate this information to State and local governments.

2. *Focus service strategies on serving the entire family.* Because of the rapidly growing number of drug-exposed babies, most will be raised in their natural families. Many families already have multiple problems, which will be compounded further by having to deal with the problems faced by drug-exposed babies. In developing its service strategy for these babies, HDS should place priority on providing needed interventions with the entire family, to help ensure that drug-exposed children can grow up in a caring and supportive family environment.

3. *Evaluate obstacles to placement.* The HDS should evaluate obstacles to foster care and adoptive placements, especially as they relate to drug exposed babies and develop strategies for overcoming them. This examination should include current policies regarding family reunification, voluntary parental termination, and restrictions on foster care and adoption.

4. *Coordinate Departmental activities.* The HDS should coordinate Departmental activities relating to drug-exposed babies and their families. This recommendation could be achieved through the expansion of the informal interagency coordination activities of HDS and the Public Health Service (PHS). Representatives from the following HHS components should be included:

- Office of Human Development Services — lead agency
- Public Health Service
  - Maternal and Child Health Services
  - National Institute on Drug Abuse
  - National Institute on Child Health and Human Development, National Institutes of Health
  - Alcohol, Drug Abuse and Mental Health Administration
- Family Support Administration
- Health Care Financing Administration
- Assistant Secretary for Planning and Evaluation

Office of Human Development Services and the Public Health Service

1. *Conduct long-term research.* The HDS and the PHS should conduct long-term research on the effects of prenatal exposure to drugs, including crack cocaine, on babies and their mothers. Specific areas where research should be conducted include:

- long-term effects of prenatal drug exposure on physical, psychological, and neurological development. Longitudinal research on these topics could

conceivably take up to 15-20 years on the same subjects, with annual or semi-annual reports of findings required.

- long-term outcomes of various treatment modalities in reducing or eliminating drug use by women of child-bearing age who are addicted to crack cocaine or other drugs.

- permanent placement options and outcomes for drug exposed babies as compared to other babies and children in the custody of child welfare agencies. The long-term resources required (staffing as well as funding) for each of these groups could also be compared.

2. *Promote drug abuse training.* The HDS and the PHS should promote drug abuse training in the following areas:

- Medical schools - Most physicians are not trained to recognize the signs of drug use. As a result, physicians are failing to identify many pregnant women who are using drugs as well as newborns exposed in utero. Medical school and continuing education curricula should include: identifying drug abuse behaviors, documenting drug and lifestyle histories, and recommending appropriate drug treatments.

- Child welfare agencies - Assistance to State and local governments should include developing and disseminating model training materials for child welfare agencies. These materials could include: techniques to recognize and assist drug abusing families and their children and examples of successful case management techniques.

3. *Promote prevention through public outreach and informational materials.* Existing anti-drug messages do not sufficiently emphasize the dangers of prenatal drug exposure. A comprehensive strategy should be developed to target women of child bearing age. This includes developing model brochures (including easy to read, illustrated formats) and public service announcements.

Public Health Service and the Health Care Financing Administration

1. *Continue to support prenatal care expansion.* The PHS and the Health Care Financing Administration should continue to support expanded availability of prenatal care to at risk mothers and their babies. This includes identifying and disseminating practices which encourage community involvement in prenatal care outreach and education.

ENDNOTES

1. Villanova University, Human Organization Science Institute, Unpublished data, 1990.

2. Prepared congressional testimony of Neil Halfon, M.D., M.P.H. cited in "Born Hooked: Confronting the Impact of Perinatal Substance Abuse," a Hearing before the Select Committee on Children, Youth, and Families, U.S. House of Representatives, One Hundred First Congress (Washington: U.S. Government Printing Office), 1989, p. 66.

3. E.S. Bandstra, B.W. Steele, G.T. Burkett, D.C. Palow, N. Levandoski, and V. Rodriguez, "Prevalence of Perinatal Cocaine Exposure in an Urban Multi-ethnic Population," *Pediatr Res*, April 1989 as cited in "Born Hooked: Confronting the Impact of Perinatal Substance Abuse," a Hearing before the Select Committee on Children, Youth and Families, U.S. House of Representatives, One Hundred First Congress (Washington: U.S. Government Printing Office), 1989, p. 6.

4. "Crack Babies: The Shame of New York," Senate Committee on Investigations, Taxation, and Government Operations, The Senate, State of New York, December 20, 1989.

5. The City of New York, Executive Budget, Fiscal Year 1990, May 18, 1989.

6. "The Illinois Model: A Statewide Collaborative Program for Alcohol and Other Drug Using Pregnant Women," issued jointly by the Illinois Department of Children and Family Services, Illinois Department of Alcoholism and Substance Abuse, and National Association for Perinatal Addiction for Perinatal Addiction Research and Education, p. 3.

7. Philadelphia Citizens for Children and Youth, "In Their Second Best Interest," 1989, p. 30.

RESPONSES OF MICHAEL MANGANO TO QUESTIONS ASKED BY COMMITTEE

1. The Inspector General's report, Crack Babies, describes the complex and time-consuming nature of drug-related child welfare cases. It also reports large caseloads for child welfare workers in many cities, as well as high staff turnover rates.

What would be the cost of reaching a reasonable caseload size in these cities?

This Office of Inspector General (OIG) report did not specifically survey the cost of child welfare services as related to caseload size.

The American Association for Protecting Children has done a cost analysis of workloads in Ohio and is currently performing such an analysis in Texas. For further information we suggest you contact Mr. John Fluke at (303) 695-0811.

It is also our understanding that Indiana, because of recent fatalities involving children, is attempting to determine the costs of reaching a reasonable caseload.

With respect to what constitutes "reasonable" caseload, the Child Welfare League of America and the National Association of Public Welfare Administrators have developed standards or guidelines (Attachment A).

What were the starting and average salaries for caseworkers in these cities?

We found starting salaries to vary greatly across the cities surveyed. At each site, salaries vary according to type of caseworker, length of experience, and shift differentials. Some representative base starting salaries are shown below:

Fort Wayne, IN	$16,068	to $24,158
Miami, FL	$16,800	to $19,800
New York City, NY	$25,000	to $27,000
Tacoma, WA	$25,236	to $32,004

A 1988 report by the National Child Welfare Resource Center for Management and Administration provided average salaries for child welfare workers by State (Attachment B).

2

What should the federal government do to help child welfare agencies cope with drug-related cases, given the federal requirements on investigations of abuse and neglect reports and reasonable efforts to prevent placement in foster care? Specifically, how should we help States reduce caseloads and staff turnover?

The OIG report contains a series of recommendations which address these issues. Specifically, State and local agencies should develop guidelines for caseworkers to follow in responding to drug exposure cases and training caseworkers to handle such cases. Guidelines should cover risk assessment, family reunification, and termination of parental rights. Caseworkers should be trained in identifying substance abuse behaviors, recording drug histories and documenting evidence for court.

At the Federal level, we recommend that the Office of Human Development Services and the Public Health Service promote drug abuse training in child welfare agencies. This includes assisting State and local governments by developing and disseminating model training materials. These materials could include: techniques to recognize and assist drug abusing families and their children and successful examples of case management techniques.

We also recommend that the Office of Human Development Services identify practices, programs, and laws or regulations considered effective in dealing with drug-exposed baby cases and disseminate this information to State and local governments.

We are also taking steps within OIG to assist in this effort. Within the next month, we will be issuing a report entitled "Model Programs Serving Crack Baby Families" (OEI-03-89-01542). This report will include practices and programs which were identified by State and local agencies as effective in assisting crack babies and their families. The OIG is also undertaking a new inspection to examine legal issues associated with children prenatally exposed to drugs.

2. The report also notes that training is essential to help caseworkers work with these families.

In the cities you visited, what was the capacity of the child welfare agencies to provide such training? For example, what percentage of caseworkers had received training specifically related to working with families where substance abuse was present? What would be the cost of adequately training the workers?

While respondents expressed a need for more training of social service and health care professionals, they did not provide specific information on the extent or costs of such training.

Most agencies reported they need workers on board so desperately, training is essentially "on the job". New York City trained 1,264 new caseworkers in 1989 which enabled the city to just keep pace with increasing caseload demands.

We identified two programs which have developed curricula involving substance abuse issues.

UCLA's Project T.E.A.M.S. (Training, Education and Management Skills) helped train workers to deal with the special needs of drug-exposed babies. The project was funded by the National Center on Child Abuse and Neglect, the HHS Office of Human Development Services and the Los Angeles County Board of Supervisors. From April 1986 through May 1988, it developed curricula and trained interdisciplinary teams of child protective workers and public health nurses to provide services for high-risk infants.

The National Association for Perinatal Addiction Research and Education (NAPARE) has developed curricula for social service and health care professionals. The NAPARE believes these professionals are unable to take adequate substance abuse histories due to poor training. Therefore, the curricula include training guidelines for the recognition and assessment of substance abuse.

How much federal funding was used to train child welfare workers in FY 1989? How much does the Department expect to spend in FY 1990? What percentage of total child welfare expenditures do these figures represent?

According to the Office of Human Development Services, Federal expenditures for training under Title IV-E are estimated to be as follows: FY 1989 - $30,607,000; FY 1990 - $48,744,000; FY 1991 - $66,779,000. Title IV-E expenditures for administration, training and maintenance payments for FY 1989 were $1,147,145,000; therefore, Federal IV-E expenditures for training in FY 1989 were about 2.6 percent of total outlays.

States may also use the Title V-B funds for training. We have no specific data on these expenditures. In addition, discretionary grants are awarded annually to colleges and universities to support child welfare training activities. In FY 1989, $3.696 million was awarded; $3.647 million is available in FY 1990.

3. The report recommends that the Office of Human Development Services "focus service strategies on serving the entire family." What are some specific ways in which this type of comprehensive approach can be achieved?

During our inspection, we found several programs which use a comprehensive approach for serving drug-affected families. The

programs provide comprehensive services and case management to families. More detailed information will be included in the previously referenced OIG report on "Model Programs Serving Crack Baby Families."

Martin Luther King Jr. Hospital in Los Angeles, California is a county facility that offers or is affiliated with four programs for drug-exposed babies and their families.

o Project Support provides prenatal care and outpatient drug treatment.

o High-Risk Infant Follow-Up provides medical care for infants at risk and ensures they receive the necessary services.

o Assistance and Relief to Kids (ARK) is a child abuse project for high-risk women.

o Eden Infant, Child and Family Development Center provides parenting education, mother-infant counseling, maternal psychological evaluations, family treatment plans, and Cocaine Anonymous meetings.

The Women's Annex in Tacoma, Washington provides transitional housing for single women recovering from drug and alcohol abuse. The Annex provides the women with a wide complement of services including day care, transportation, counseling, parenting classes, recreation, and employment and education resource referral.

The Public Health Service, Office of Substance Abuse Prevention, is currently providing $5.2 million for 20 demonstration projects designed to (a) promote the coordination of service delivery (b) increase the availability of prevention and treatment services and (c) improve the birth outcomes of women who used alcohol and other drugs during pregnancy. (Attachment C.)

4. The report recommends reducing barriers to placing drug-exposed children in foster or adoptive homes. Did the study identify any programs that were successful at preserving families where substance abuse was present and, if so, what were their characteristics?

St. Lukes/Roosevelt Hospital Center in New York City has a Prevention Unit which serves multiproblem families. The goals of the program are to prevent foster care placement, reduce the incidence of child abuse and neglect, improve the parent's ability to deal with psychosocial crises, and foster the personal development of parents and children.

The staff creates a strategy for each family which includes coordinating services such as counseling, crisis intervention, home visits, and parent-child interaction therapy.

Attachment A

GUIDELINES

for a
Model System
of
Protective Services
for
Abused and Neglected Children
and
Their Families

National Association of Public Child Welfare Administrators • An Affiliate of the American Public Welfare Association

WORKLOAD STANDARDS IN CHILD PROTECTIVE SERVICES

by Homer D. Kern, Ph.D.
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In Child Protective Services (CPS), workload standards are the formal or informal expectation of how much time it should take, on the average, to complete the services provided for each of the various types of cases involved. These standards are how much time it should take under normal conditions, not how much time it currently takes; they are judgments of what should be, not what empirical data is. For example, if completing an intake investigation normally takes 25-35 hours, but because of staff shortages workers are currently doing the job in 12-15 hours, then setting the standard at the current level would perpetuate poor casework and low morale and would not provide adequate protection for children.

For practical purposes, individuals generally use the term caseloads when talking about standards. However, a distinction must be made between caseloads and workloads, because workers may have equal workloads. For example, significantly more time is required to work 20 intake-investigation cases than 20 in-home services cases. Therefore, it is imperative that standards be stated as workload (in terms of time) rather than caseload. But for practical purposes not related to the calculation and comparision of workloads, the standards can be translated into equivalent caseloads.[1]

Since standards represent the norm, they should be stated as the average time it takes the average experienced worker to complete the average case. Therefore, exceptions will occur where individuals are legitimately out of compliance with the standards. For example, a new worker would not be expected to immediately perform at the level of the standards. Such reasons for noncompliance are easily documented.

Applications/Uses Of Workload Standards

Numerous useful applications for standards exist. Some of the more important applications are explained below. Many more uses exist, but these few demonstrate the importance of developing workload standards for Child Protective Services.

Funding

One of the most crucial applications of workload standards is in the process of requesting appropriations. Standards can be used in conjunction with projected numbers of cases as empirical evidence of the real level of staffing need. Salary, overhead, and benefits can then be used to calculate projected costs.

Staffing Allocation

Standards offer an objective procedure for allocating staff positions between units, counties or regions in a manner that will assure equity of workload to the staff, and, as a result, equity of service to the clients.

Equity of Workload

When staff are equitably allocated to units, an ongoing need remains to maintain workload equity between the individual workers in the unit. Workload standards make it possible to do that.

Equity of Service

When workload standards are used to ensure workload equity between workers, they also ensure time is available for endeavors as critical as protecting children from physical harm, injury or death. It is unconscionable to allow large imbalances in workload for long periods of time.

If the supervisor of a generic unit applies the additional criteria of worker expertise to assigning cases, then randomness is abandoned and even greater inequity of workload will result over time. Even the supervisor who conscientiously maintains an equity of caseload will not be able to maintain an unbroken equity of workload over an extended period of time, since the time to deliver services to various types of cases is so different.

Using workload standards in the case assignment process will provide an ongoing equity of workload, making possible an equity of service to clients and a great reduction in the risk of harm for many of the children served.

Methodology

Workload standards can be developed for any size Child Protective Services agency, regardless of how it is organized: by state, region or county, or an individual private agency. The same overall methodology applies to all of these types of organizations. The primary difference is that the larger organizations have more options than the smaller ones.

Who Sets Workload Standards

There are a variety of options for setting standards. Administrative staff can set the standards themselves, but such standards will not be well accepted and may not be valid. A better approach would be to appoint a workload standards committee composed of experienced and knowledgeable staff members of various levels, workers through administrators. Members of this committee would use their judgment to set the standards.

Another good approach for large agencies is to appoint a hierarchical task force composed of a workload standards committee from each geographic region of the state, and a state committee composed of representatives from each of the regional committees. Members of the state committee can perform the final function of setting the standards using the information brought from the regions, or they can synthesize the statewide input and pass it along to a higher level committee which would set the final standards.

Whatever structure is chosen, there are certain functions which must be performed if the process of setting and using standards is to be successful. Workers and supervisory level input must be obtained, and upper-level management must express a commitment to the process, and must use it.

The Process of Defining Service Categories and Tasks

One of the first things that must be done in order to set workload standards is to define the service categories and tasks of the Child Protective Services workers. Some agencies may already have succinct, yet complete service categories defined. However, many will need to formally identify the activities which make up their units of service or case types and briefly and accurately define both the units of service and the tasks. For example, units of service would include activities such as intake investigations, in-home services, and working with children in substitute care, etc.; tasks would include activities such as direct contact with clients, collateral contact, and case recording.

All services and tasks, including both administrative and case-related categories, need to be identified and defined with specific beginning and ending points. This process can be completed by a single purpose committee composed of various levels of staff with a heavy representation of field staff, or it can be completed by the workload standards committee as one of their first tasks. Whichever approach is taken, remember that field staff frequently prefer to include individual items rather than grouping some small items together. Since it is important to be as concise as possible, some items need to be consolidated into larger categories. Therefore, to achieve a more useful product, a person with less at stake who can maintain more objectivity, e.g. an administrator or management support staff member, should facilitate the meetings to define service categories.

The Process of Data Collection

To set standards on how much time it should take to complete the various Child Protective Services, it is necessary to first know how long it is taking under current circumstances. They may require workers to spend more or less time on certain activities than they should. Therefore, current time frames should not automatically become the standard. However, knowing how long it currently takes to perform an activity provides a frame of reference to which additional information on why it takes the time it does can be applied. A review of this information can then be used to help guide the setting of standards at what they should be.

To do this review, empirical data must first be collected to determine the average time for completing services. There are only two methods of data collection which are appropriate for use in setting workload standards for Child Protective Services, time log and estimation.[3]

The time log method requires workers to record on a daily log the total time they spend on each activity for the entire designated reporting period. Estimation can take one of several forms. Any valid structured estimation process, including face-to-face meetings, or a modified Delphi method, which utilizes structured questionnaires rather than group meetings, can be sufficient.

Regardless of the method used, certain distinctions must be made. Both administrative and case-related time must be captured separately. This is necessary because the standards will relate to individual case-related activities and because the formulas for converting time into caseload and for calculating individual workload time require this distinction.

The Process of Getting Field Staff Input

The more precise methods of setting workload standards require that the staff who are setting the standards must review selected field staff opinion of what the standards should be, as well as review the data on the time it currently takes to complete the services. There are three standard methods for getting this informed field staff input.

The first approach to getting field staff input is for the people who will be setting the standards to meet separately with selected individuals who have received the empirical data on current work measurement times to solicit their input on what they believe the standards should be. This would be a very time consuming procedure for large agencies; however, it would be practical in some organizations that have large geographical regions with few staff members in each region.

The second approach is to use a questionnaire, rather than face-to-face meetings, to obtain field staff input on what they believe the standards should be. The work measurement data on how long it currently takes to deliver services could be mailed along with a questionnaire designed to solicit field staff opinion on how long it should take. The advantage of this approach is that it is possible to get input from more people. The disadvantage is that it should be designed and administered by research experts experienced in the scientific collection of opinions. This can be an expensive approach, but it also can give very acceptable results.

The third approach is to use a committee or task force which brings the individuals who will be setting the standards face-to-face with field staff to get their input on what the standards should be. This process would also have the field staff reviewing the work measurement data on current times before the meeting, during the meeting, or both. This too is a method which can result in very acceptable results.

The Decision Making Process

There are five major approaches to setting workload standards in CPS. The first approach is very simple; it is to do nothing. If formal standards are not set, it does not mean that there are no standards, rather that there are only informal standards. In the absence of a formal standards process, informal standards are the expectations communicated directly or indirectly to staff regarding the amount of work they are expected to perform. Informal standards in CPS agencies most often are expressed as the number of cases workers are expected to carry. These informal, unscientific standards are not effective for controlling workload or for other important functions, such as giving credence to appropriation requests. Nonetheless, they are widely used.

The second approach also is simple; it is for management to set the standards by fiat. This means formally stating the standards without any input from field staff. Even if management was capable of accurately setting the standards alone, it would not be a good approach because field input would be needed to give credibility to the standards. For standards to be used appropriately, the staff using them must believe in them. Otherwise the standards will be acknowledged to fulfill formal requirements but will not actually be used.

The third approach is to use a majority vote to decide the final setting of each standard. This is an acceptable procedure which can result in valid standards; however, when the vote is not unanimous, some members of the process may think that the standards are somewhat less accurate than they could have been.

The fourth approach is to use a modified Delphi method or other questionnaire process to make the final decision on each standard. This method can be effective, but it will be time consuming, and for best results, it should be conducted by experienced researchers.

The fifth approach is to use a consensus model for decision making on each standard. This is similar to the voting model; however, it has the advantage of reaching final decisions with agreement by all participants through the process of communication and compromise. It is usually more difficult and more time consuming than the voting model, but the result is a set of standards in which everyone shares ownership. This approach has the greatest liklihood of success.

The Form of Workload Standards

Workload standards may take a variety of forms, such as a productivity index, a weighted or unweighted caseload system, or a service completion time model. The productivity index and the caseload systems both require a great deal of time for updating and are difficult for many people to understand and use appropriately. The service completion time model gives the best results for the resources required. It is a straightforward approach of stating the standards as the time required to complete each unit of service, such as an intake investigation. These completion times should be tied to duration of the services and frequency of client contact to prevent workers from manipulating the standards.

In business and industry, workload standards are stated as minimum standards. For example, industrial employees are expected to produce a minimum number of widgets in a specified time. In Child Protective Services this model is not appropriate, because a minimum caseload standard can be maintained or surpassed by a worker simply by reducing the frequency or duration of client contacts or by holding cases open that are ready for closure.

For this reason, a maximum caseload is a more appropriate standard for CPS workers. With a maximum caseload standard, the worker must maintain the case contacts, not allowing their duration to extend into longer visits than necessary. The efficient worker's caseload will be lower after a period of time than the inefficient worker who has been assigned the same number of cases, because by getting the work done quicker, the cases are closed sooner. However, as explained earlier, service completion time is the best method of stating workload standards in CPS. Using this method, the lower the completion time, the higher the caseload.

When workload standards are used for management purposes, it should be remembered that "in Child Protective Services cases, the variety of activity and demand for worker time is extremely varied, even within the same case type, making it impossible to always meet precise standards."[3]

Therefore, a method for dealing with noncompliance is necessary. It can be handled on an individual exceptions basis, or a standard approach can be devised to accommodate most of the occasions when a worker would be out of compliance.

One way to establish a standard approach is to use a range of standards, preferably from optimum to maximum, large enough to account for most of the normal deviation in service completion time. Any time between the end points of the range would be considered to be in compliance with the standards. If this is done, many fewer instances of legitimate noncompliance will occur.

However, for some purposes, such as appropriations requests, a range is not appropriate. In these cases, a specific amount rather than a variable amount of dollars will be appropriated; therefore, specific standards, rather than a range will be necessary. For these purposes, it is best to use the low end of the time range, which is the high end of the caseload range. Political realities would preclude anything else. However, explaining that this is the high end of the caseload range will help the funding body to understand that the funding request is for the minimum amount of staff time required to do the job.

Footnotes

1. For a more detailed look at workload standards, including a formula for converting standards into caseloads, see Homer D. Kern, "Workload Standards," in *Caseload and Resource Management*, Edited by John Fluke. Denver: American Association for Protecting Children, in press.
2. Peat, Marwick, Mitchell & Co. in association with Child Welfare League of America, *Developing Workload Standards for Children and Family Social Services*, DHEW Publication No. (OHDS) 78-30136, 1978.
3. Homer D. Kern, "Child Protective Services Workload Analysis and Management," *Protecting Children 4* (Spring 1987): 4-6.

Attachment A

CWLA STANDARDS

Each STANDARDS volume defines the nature of the particular service, its physical structure, the phases of the social work process with each client generically involved, the roles and responsibilities of each category of staff, and community planning and organization of the service as a whole.

The format of each volume is similar: each STANDARD is numbered, with subsumed elaboration, and it is also cross-referenced and indexed. CWLA STANDARDS published since 1984 and all subsequent volumes are 3-hole punched. Each volume has its own cover/divider and identifying tab and is packaged individually.

CWLA Standards for Health Care Services for Children in Out-of-Home Care
1988/paper/0-87868-378-X/#3780 $12.50

CWLA Standards for Adoption Service
Revised 1988/paper/0-87868-365-8/#0173 $12.50

CWLA Standards for Child Protective Service
Revised 1973/85pp/paper/2nd prtg/0-87868-113-2/#1132 $12.50

CWLA Standards for Services for Pregnant Adolescents and Young Parents
Revised 1986/74pp/paper/087868-270-8/#2708 $12.50

CWLA Standards for Day Care Service
Revised 1984/105pp/paper/0-87868-237-6/#2376 $12.50

CWLA Standards for Organization and Administration for All Child Welfare Services
(serves as the basic companion volume for all programmatic standards)
1984/122pp/paper/0-87868-222-8/#2228 $12.50

CWLA Standards for Residential Centers for Children
1982/168pp/paper/0-87868-179-5/#1795 $12.50

CWLA Standards for Foster Family Service
Revised 1975/125pp/paper/0-87868-114-0/#1140 $12.50

CWLA Standards for Group Home Service for Children
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STANDARDS FOR RESIDENTIAL CENTERS FOR CHILDREN

Agencies are encouraged to conduct their own workload analysis to obtain a relevant caseload size. The caseload sizes below are general recommendati and based on a worker providing the services recommended in the CWLA stand

SERVICES FOR ABUSED OR NEGLECTED CHILDREN AND THEIR FAMILIES

Caseloads should be determined on the following factors:

-- The specific functions assigned and the time required for each (e.g. intake, court work, placements)
-- Skill and experience of the social worker
-- The geographical distance to be covered
-- The availability of other services (e.g. in-home parent aides, foster homes)
-- The intensity of services required
-- The number of other agencies involved with the family
-- The amount of time required for other activities

INTAKE/INVESTIGATION (to be completed within 60 days)

12 active cases per month per 1 Social Worker

ON-GOING CASES

17 active families per 1 Social Worker
no more than 1 new case assigned for every 6 open cases

COMBINED INVESTIGATION AND ONGOING

10 active on-going cases and 4 active investigation per 1 Social Worker

SUPERVISION

1 Supervisor per 5 Social Workers

The CWLA Standards outline the services that are recommended for good practice in each program. The caseload size below is based on a worker being able to provide these services.

SERVICES TO STRENGTHEN AND PRESERVE FAMILIES

FAMILY CENTERED CASEWORK SERVICES

Factors determing caseload size:

-- Sufficient time to help family achieve goals within a limited time frame

-- Time needed to arrange other services, staffing, documentation, advocacy, monitoring and periodic reviews

12 families per 1 Social Worker

INTENSIVE ~~[illegible]~~E FAMILY CENTERED CRISIS SERVICES

Factors determing caseload size:

-- Allow for 8 to 10 hours per week in face to face contact with families

-- The phase of service-allowing 20-25 hours of face to face contact per week at intake

2 to 6 families per 1 Social Worker

The CWLA Standards outline the services that are recommended for good proctice in each program. The caseload size below is based on a worker being able to provide these services.

IN-HOME AIDE SERVICES

In-Home Aide

Factors determining caseload size

-- The range of specific responsibilities assigned to the aide
-- The nature of the problems in the families assigned
-- The geographical area to be covered

10 families per 1 In-Home Aide

In-Home Aide Social Worker

Factors determining caseload size:

-- The time required for intake, supervision with aide, and monitoring continued service
-- Time for coordination with other professionals involved with the family

17 families per 1 Social Worker

The CWLA Standards outline services that are recommended for good practice in each program. The caseload size below is based on a worker being able to provide these services.

ADOPTION

Factors to determine caseload size of social workers:

-- Sufficient time to complete intake
-- Assessment and preparation of the child for placement
-- Recruitment, screening, assessment and preparation of adoptive parents
-- Post-placement services
-- Post-legal services
-- Age of child
-- Time required for in-service training, staff meetings, other duties

Social Worker for children under 5 years of age

20 children per 1 social worker

Social Worker with prospective adoptive families

30 families per 1 social worker

Social Worker for children 5 years and older

10-12 children per 1 social worker

Other staff needed on a consultation basis:

Pediatrician	Religious counselors
Obstetricians	Psychologist
Lawyer	Psychiatrist
Educator	

The CWLA Standards outline the services that are recommended for good practice in each program. The caseload size below is based on a worker being able to provide these services.

SERVICES FOR PREGNANT ADOLESCENTS AND YOUNG PARENTS

-- Services should include casework, family counseling, case management, and group practice
-- one case would include the pregnant adolescent, father or young parents their children and families

20 to 25 cases per 1 Social Worker

The CWLA Standards outline the services that are recommended for good practice in each program. The caseload size below is based on a worker being able to provide these services.

RESIDENTIAL CENTERS

A Living Group is defined as children who eat, sleep, play and work together

CHILD CARE STAFF - the adults responsible for the children in the living group

The number of child care staff should be based on the following:

--The difficulty of the problems of children in care

-- Allowance for time off, holidays, vacations

-- 24 hour coverage

-- The same team assigned to a living group

-- More than one adult available after school, waking hours, meals, bedtime

6 to 8 children per 2 or more staff

SOCIAL WORK STAFF

Caseloads should be based on the following factors:

-- The number of cases involving intensive individual work with children and / or parents

-- Time required for individual conferences and recording

-- Time required for consultation

-- Responsibilities other than direct work with children or parents

-- The number of after-care cases assigned

12 to 15 children plus parents per 1 Social Worker

The CWLA Standards outline services that are recommended for good practice in each program. The caseload size below is based on a worker being able to provide these services.

GROUP HOME

A group home is defined as 5 to 12 children per home with 6 to 8 children optimum.

CHILD CARE STAFF - the adults in charge of daily living of the children

Considerations for staffing should be based on the following:

-- The number of children in care
-- The age of the children
--Complexity of the problems of the children
-- Amount of services needed
-- Intensity of work with child and/or parents
-- Amount of time required for individual and staff conference
-- Responsibilities other than direct work with children
-- Allowance for 2 days off per week
-- Compliance to the wage and hour legislation
-- 1 staff in the home at all times
-- More than 1 staff when all children are present
-- No staff in charge for more than 40 consecutive hours

5 to 12 children per 4 child-care staff per week

SOCIAL WORK STAFF

Considerations for caseload size based on the following:

--Intake responsibilities assigned

-- Time required for individual work with children

-- Time required for individual on-going work with parents and family

-- Time required for collaboration with group home staff and other consultants

-- No more than 1 social worker per group home

20 - 30 children per 1 Social Worker

Other staff needed on a consultation basis:

Psychiatrist	Nutritionists
Mental Health Professional	Pediatricians/Internist
Tutors	Legal Councel

The CWLA Standards outline services that are recommended for good practice in each program. The caseload size below is based on a worker being able to provide these services.

FOSTER CARE

Factors affecting caseload size:

-- Allows time to have a sufficient number of contacts with the child, birth family and foster family to implement a permenent plan
-- The number of different foster homes and birth families in a caseload
-- The number of older children in the caseload
-- The physical, mental, emotional state of the child
-- The stage of placement - a newly placed child requiring more time
-- Allowing more time for specialized foster care
-- The intensity of casework planned
-- More time allowed when the number of adults involved increases (parents, relatives, school, treatment staff, etc.)
-- The experience and skill of staff
-- The amount of support staff available (e.g.- case-aids)
-- The number of additional duties required such as : intake, aftercare, recruitment, homestudies
-- The extent of the geographic area to be covered

20 - 30 children per 1 Social Worker

The CWLA Standards outline services that are recommended for good practice in each program. The caseload size below is based on a worker being able to provide these services.

DAY CARE

-- Staffing requirement for the youngest children in a group should be followed in mixed-age groups if the youngest age catagory makes up 20% or more of the group.
-- If children in the youngest age group make up less than 20% of the group the staffing requirements for the next highest age category should be followed.

Age of Child	Staff / Child Ratio
under 3	1 : 3
3 to 4	1 : 7
4 to 5	1 : 8
5 to 6	1 : 9
6 to 12	1 : 10

National Study of

Public Child Welfare Salaries

Peter Lindsey

National Child Welfare Resource Center
for Management and Administration

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207/780-4430
Helaine Hornby, Director

This study was supported by a grant from the U.S. Children's Bureau, Administration for Children, Youth and Families, Department of Health and Human Services, Washington D.C. #90-CW-0755-3.

1988

National Survey of Child Welfare Workers

Impact of Education on Attitude and Perceptions

Alice Lieberman, Ph.D.

and

Marilyn Russell
Helaine Hornby, M.A.

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This study was supported by a grant from the U.S. Children's Bureau, Administration for Children, Youth and Families, Department of Health and Human Services, Washington, D.C. #90-CW-0755-3

Table 1

Average Salaries of Direct Service Child Welfare Workers[1] by State, and State Rankings by Average Salary, by Population, by Population Density, and by Per Capita Income.

State	Average Salary 1987[2]	Salary Rank	Rank By Population (1986)[3]	Rank By Population Density (1986)[4]	Rank By Personal Income Per Capita (1986)[5]
US[6]	23,043				
AK	32,574	1	50	51	1
DC	29,914	2	47	8	2
CT	28,100	3	28	5	3
NJ	26,517	4	9	2	4
IL	26,302	5	5	13	11
NV	25,708	6	43	47	13
MN	25,656	7	21	33	15
NC[7]	25,416	8	10	18	29
CA[8]	25,262	9	1	13	8
UT	25,179	10	35	43	48
WI	25,052	11	16	25	22
NY[9]	24,898	12	2	7	7
WY	24,696	13	51	50	27
VT	24,627	14	49	31	25
MI	24,388	15	8	15	21
AZ	24,107	16	27	40	29
HI	24,000	17	39	14	18
NM	23,820	18	37	44	44
ND	23,820	18	46	49	36
VA	23,784	20	13	17	12
MA	23,656	21	12	4	6
DE	23,640	22	48	8	14
ID	23,504	23	40	44	42
WA	23,318	24	19	29	17
MD	23,125	25	20	6	6
TX	23,022	26	3	30	28
IA	23,015	27	29	34	31
CO	22,998	28	28	38	10
FL	22,937	29	6	11	26
KS	22,836	30	32	39	19
GA[10]	22,387	31	11	23	32
OR	22,134	32	26	36	34
WV	22,022	33	34	36	50
PA	21,864	34	4	9	23
AL	21,351	35	22	27	46
OR	21,342	36	30	40	30
ME[11]	21,310	37	38	37	37
OH[12]	21,122	38	7	10	26
AR	20,793	39	32	35	49
LA	20,718	40	18	23	39
MT	20,342	41	44	48	43
SC	20,148	42	24	20	47
NH	19,900	43	41	30	9
NE	19,824	44	36	42	24
SD	19,728	45	45	47	41
RI	19,728	46	42	3	16
MS	19,724	47	31	33	51
KY	19,500	48	23	24	45
MO	19,428	49	15	28	25
TN	18,252	50	17	19	40
IN	17,797	51	14	16	33

See Appendix A to translate the abbreviation of states.

1 "Direct Service Child Welfare Workers" is defined as workers involved directly in protective services, foster care, and/or adoption, but not in supervisory positions.

2 Average salary (mean) is based on job descriptions for direct service child welfare workers. For full data on salary ranges, see Appendix A.

3 Source: National Data Book and Guide to Sources, Statistical Abstract of the U.S. 1987, U.S. Dept. of Commerce, Bureau of the Census, p. 23.

4 Population Density is figured on size of population per square mile of land area. Source: National Data Book and Guide to Sources, Statistical Abstract of the U.S. 1987, U.S. Department of Commerce, Bureau of the Census, p. 23.

5 Source: Statistical Abstract of the U.S. 1987, U.S. Department of Commerce, Bureau of the Census, p. 429.

6 U.S. Salary Average includes all fifty states and the District of Columbia.

7 North Carolina is state-supervised but county-administered. The salary range used to calculate the average is the state standard. Some counties have a higher or lower range than the state standard.

8 California is state-supervised but county-administered. The salary ranges come from a sampling of counties, both large and small. The ranges used to compute the average are not definitive as one of counties were surveyed.

9 New York is state-supervised and county-administered. The average is based on salary ranges from the Annual Salary Tabulation for Selected Social Service Titles 1987, compiled by the Local Agency Unit, Office of Human Resources Management, State of New York.

10 Georgia is state-supervised and county-administered. Therefore the salary ranges are regulated state-wide, but the workers are hired by each county.

11 Maine has recently passed in its legislature a 3 percent raise effective on January 1, 1988 with another 3 percent raise effective January 1, 1989.

12 Ohio is county state-supervised and county-administered. The salary ranges provided are estimates of the maximum and minimum salaries in the various counties. The state recommends to the counties a minimum salary of $15,220 and a maximum of $20,145. This yields an average salary of $18,288, lower than the actual average in the table.

attachment C

28-384 0 - 90 - 4

OSAP/CMCH
Funded Projects FY 1989
"Model Projects for Pregnant and Postpartum Women and Their Infants"
Demonstration Grant Program

APPLICANT ORGANIZATION	CITY	STATE	GRANT NUM	DIRECT COST	ESTIMATED INDIRECT	ESTIMATED TOTAL
New York City Department of Health	New York	NY	1691	296,045.00	17,009.00	313,054.00
Bulloch County Board of Health	Statesboro	GA	1189	172,417.00	17,242.00	189,659.00
Massachusetts Health Research Institute, Inc.	Boston	MA	1144	217,467.00	25,199.00	242,666.00
The Multnomah Cty. Office of Women's Trans. Serv.	Portland	OR	1552	209,559.00	9,694.00	219,253.00
Georgia Mental Health Institute	Atlanta	GA	1198	196,473.00	81,677.00	278,150.00
University of Wisconsin-Madison	Madison	WI	1641	219,486.00	78,974.00	298,460.00
Robeson Health Care Corporation	Penbroke	NC	1601	292,485.00	29,249.00	321,734.00
Maternity Infant Care-Family Planning Projects	New York	NY	1150	232,665.00	23,207.00	255,872.00
Logan Heights Family Center	San Diego	CA	1621	231,170.00	19,517.00	250,687.00
Model Cities Health Center, Inc.	St. Paul	MN	1610	184,648.00	18,465.00	203,113.00
St. Vincent Medical Center, Dept. of Pediatrics	Toledo	OH	1107	199,886.00	19,989.00	219,875.00
Emanuel Hospital and Health Center	Portland	OR	1562	256,826.00	115,572.00	372,398.00
Aplalachee Center for Human Services, Inc.	Tallahassee	FL	1179	299,440.00	29,440.00	329,384.00
University of S. Florida, Coll. of Public Health	Tampa	FL	1559	201,165.00	20,117.00	221,282.00
University of Washington Hospital Medical Center	Seattle	WA	472	161,703.00	34,452.00	196,155.00
University of New Mexico, School of Medicine	Albuquerque	NM	1450	181,408.00	18,140.00	199,548.00
Shands Hospital, Dept. of Social Work	Gainesville	FL	1679	193,560.00	34,840.00	228,400.00
Contra Costa County Health Serv. Dept.	Martinez	CA	1151	280,000.00	28,000.00	308,000.00
Detroit Health Department	Detroit	MI	1619	297,045.00	*	297,045.00
Idaho Primary Care Association	Boise	ID	1593	298,214.00	*	298,214.00
						5,242,949.00

* Indirect Cost Rate To Be Negotiated

Senator COATS. Dr. Chasnoff.

Dr. CHASNOFF. Yes. Thank you, Senator Coats.

As one looks at figures and tries to find how many babies have been exposed to various drugs, not just cocaine, throughout the country, it is clear that one of the difficulties with most of the surveys that have been done have relied on data based on children reported to the child welfare system, children reported to child protection services, and almost all the studies are always based on inner-city, large urban area populations.

We recently had the opportunity to do a population-based study which included women in prenatal care in a private health care setting. What we found, when looking at 715 women who were concurrently in prenatal health care at their first prenatal visit, of the 715 women, 14.8 percent had a positive urine toxicology for either cocaine, marijuana, or heroin.

When you divided that between the 380 women in private health care versus the 335 women in a public health care setting, 16 percent of the women in public health care had a positive urine, but among women in private health care, 13 percent had a positive urine toxicology.

Taking it one step further, we then divided the women along racial lines. We eliminated Oriental and Hispanic women because there were not enough in the population. We had approximately 200 black women and approximately 500 white women in the study.

We found, contrary to what would have been predicted by many health care practitioners, we found that the rate of positive urine toxicologies among the black women was 14 percent and the rate among white women was 15.4 percent. So it was actually even.

However, when we then looked at what babies were being reported under Florida's child abuse reporting laws, we found that black babies were being reported at a rate ten times higher than white infants. Physicians were selecting out those women who they perceived as drug abusers to test those babies and then reporting them through the system.

There are many possible explanations for this. This paper is going to be published next month in a medical journal, and we go into some of those explanations at that point.

But I think it points up the fact that we have a very difficult time. I have heard a lot of numbers thrown around here today. But essentially we do not know how many children have been exposed to drugs during pregnancy.

There are many groups across the country that have been doing studies looking at the short-term outcome. We now know that these infants have an increased rate of premature delivery, low birthweight, which of course leads to our country having the highest infant mortality rate among the developed nations of the world.

We also know that these children have increased rates of seizures, sudden infant death syndrome, and other complications.

Our 2-year studies currently, we have just analyzed our data for infants 2 years after delivery, and have found that infants exposed to cocaine during pregnancy, when controlling for all the other environmental issues that one must look at, we have found that these infants, having normal developmental quotient—that is, they per-

form normally; they are not "retarded"—but at the same time their behaviors are abnormal, and that these children, in order to perform, must have a very structured environment.

Whereas a normal child can select out, for example, cubes if you give a normal child eight cubes in a little cup, they can select out three cubes to put into the cup. But a cocaine-exposed infant will look at the cubes spread out before him and will look at the cup and become very frustrated and sweep the cubes off the table.

We look at this as a difficulty in organizing behavior, and we find as we track these children long-term they are having difficulty taking messages in and then interpreting them within their brain and putting out the right type of behavior in response.

We can predict from looking at this that as these children reach the educational system, these children are going to put great demands on teachers and on classrooms, where certainly we know across the country classrooms are very unstructured at this point and we do not have the facilities or the personnel to address this issue.

What can we do about it? We have to go out into the community and begin developing programs that will bring women into prenatal care. The issues we are facing are not issues of substance abuse, they are issues of access to health care. The great majority of women, no matter how many programs you develop, the great majority of women who are using drugs do not get prenatal care. Up to 60 to 70 percent of drug-using women have no prenatal care.

What are the barriers? Simple ones: transportation, child care, coordinated programs that provide them prenatal care with substance abuse treatment at the same site, and not women falling into the trap of being given an appointment for their substance abuse treatment six months down the road when they will no longer be pregnant, because there are no programs open at the time.

The other problem is that the health care professionals have failed in duty to this population and that most physicians do not know how to recognize a substance-abusing pregnant woman, they do not know how to take an appropriate history, and so they begin to rely on urine toxicologies, which in fact will only pick up those women who happen to have used in the last 48 hours.

We have to work with the medical community to get them in tune with the times, to develop programs for physicians so that they can learn not only how to talk to their patients but to refer them into treatment. And that is the only way, by starting at the very basis of our health care system, that we are going to be able ever to approach this problem.

Senator COATS. Thank you.

[The prepared statement of Dr. Chasnoff follows:]

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National Association for Perinatal Addiction Research and Education
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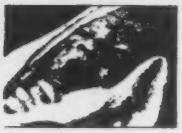
312/329-2512



PREPARED STATEMENT OF IRA J. CHASNOFF

Although problems of substance abuse in pregnancy have received increasing attention since the early 1970's, there has recently been a very rapid increase in the concern for the infants born to alcohol and other drug using women. The reasons for this concern are easily understood when current statistics from the National Institute on Drug Abuse are reviewed. Although patters of abuse of alcohol, marijuana, heroin, and other substances by women of childbearing age have changed very little over the last 10 years, the incidence of cocaine use in this special population has been rising rapidly, a reflection of cocaine's increasing popularity among the general population of the United States.

EPIDEMIOLOGY

Early studies evaluating drug use by women during pregnancy revealed that around 50 to 60 percent of women used some analgesics during pregnancy, and sedative drug use by pregnant women ranged around 25 percent. Most of the women involved in studies such as these were women who were receiving prenatal care and were obtaining many of the medications by prescription from their physicians. Use of illicit drugs rarely was considered. During a 6-month period in 1982, screening of all women enrolling at Prentice Women's Hospital and Maternity Center for routine prenatal care revealed that 3 percent of these women had sedative-hypnotics in their urine at the time of admission to the general maternity clinic. This study was performed prior to cocaine's becoming society's drug of choice. Currently, with an estimated 20 million Americans having tried cocaine at least once, and 5 million using it on a regular basis, the number of pregnant cocaine users in the United States has risen rapidly. A recent study by the National Association for Perinatal Addiction Research and Education (NAPARE) of 36 hospitals from around the country showed the overall incidence of substance abuse in pregnancy was 11% with a range of 0.4% to 27%.

2

Studies from specific hospitals revealed the following rates:

Name/Hospital	Method	N	Percent
Little Parkland Dallas, TX	History, intake into prenatal clinic	3000	9.8 coc 3.0 amph
Roger Shands Gainesville, FL	Urine on consecutive newborns	100	10 coc
Wong San Francisco General	Urine on all NBs in one month	170	10 coc
Burkett Bandstra Jackson Memorial Miami, FL	Urine on consecutive women at L/D	300	12.5 coc
Bateman Harlem Hospital New York, NY	Urine on all NBs	3000	15 coc
Rahman Chicago Osteopathic Chicago, IL	Urine on all NBs May/June '88	158	16 coc
Zuckerman Boston City Boston, MA	History, urine on study participants	1600	17 coc 27 mj
Colmorgen Christiana Newark, DE	Urine at first prenatal visit	1500	24 all drugs
Evans University of California, Davis	Urine on every woman at L/D	800	25 coc amph her

As further studies have been conducted, we have found that rural areas of the United States have not been spared. For example, in Winatchee, Washington, 25-30 babies per week are delivered at the community hospital. Among these 3 to 4 per week are reported to the Child Protective Services team due to having cocaine in their urine at birth (Pat Boggess, M.S., Child Protective Services, Division of Children and Family Services, State of Washington). In September, we will be releasing the results of our current study in Pinnellas County, Florida, which is examining and comparing the

rates of positive urine toxicologies in pregnant women in private obstetric care versus pregnant women in public health clinics. In New York City, it was estimated that 50 percent of all child abuse and neglect cases involved drug abuse, and if alcohol was included, substance abuse was involved in 64 percent of child abuse cases. In a survey conducted by the Child Abuse Prevention Program, Department of Health Services In Los Angeles, California, of a total of 5973 cases of child abuse reported in 1985, 538 cases (9 percent) involved neonatal withdrawal due to maternal drug use in pregnancy. In the first 6 months of 1986, 403 of 4299 cases (9.4 percent) of child abuse were reported due to maternal addiction during pregnancy. The patterns of drug use in this population showed a shift toward a higher frequency of cocaine use among the reported cases in the first 6 months of 1986 as compared to 1985.

In 1985, Illinois child welfare professionals began to express growing concern over the large numbers of alcohol dependent families in their caseloads. In order to gain some perspective on the extent of the problem in Illinois, several surveys were undertaken. Initially, experienced supervisors were selected on a random geographical basis and asked to indicate the percentage of neglect cases in which parental alcoholism or drug dependence was a problem. Between July 1, 1985 and March 1, 1986, over 11,000 cases of neglect had been reported which included parental alcoholism and/or drug dependence as problems. Further, they also reported that in 75% of the cases, alcoholism was the mother's problem rather than the father's. Additionally, several Illinois alcoholism treatment programs were contacted to determine the percentage of women served in their program who had engaged in neglectful behavior toward their children. In fact, 50% of the women had lost custody of their children prior to entering the program. The Sheltering Arms Alcoholism Treatment Program in Joliet, Illinois, reported that almost all of the women in a typical Alcoholics Anonymous meeting self reported child neglect.

A 1987 Illinois survey reported that in 50% of the families with children in placement, maternal alcohol or substance abuse was known or suspected. This figure reflects the low end of the national perspective as detailed in a 1986 Prevention Report which stated "there are estimates that as many as 50 to 75% of clients (in public agency caseloads) have an alcohol-related problem." Of course, the linkage between alcohol/substance abuse and poor parenting was not newly discovered. It had been consistently documented in the alcoholism literature for over ten years. Yet, in spite of this longstanding and well-documented linkage of parental alcoholism and child neglect, there remained a curious paucity of multi-disciplinary education/training and documented collaborations between alcoholism and child welfare professionals. These groups often worked separately within their own areas of expertise. The results were not encouraging.

4

NEONATAL SYMPTOMS

The fact that drugs cross the placenta and reach the fetus creates potential problems of fetal development. These problems can be manifested as congenital abnormalities. In addition, one of the important effects of maternal drug use during pregnancy, especially use of drugs with high potential for abuse, is that dependence develops in the fetus as well as the mother. Thus, the opiate-exposed fetus will experience withdrawal when the mother is withdrawn from her drug or at term when the maternal drug use no longer provides the newborn with drugs.

Symptoms of neonatal withdrawal are often present at birth but may not reach a peak until 3 to 4 days of life or as late as 10 to 14 days after birth. The most common features of the neonatal abstinence syndrome mimic aspects of an adult withdrawing from narcotics. Most significant for the neonate are the high-pitched cry, sweating, tremulousness, excoriation of the extremities, and gastrointestinal upset. Withdrawal from narcotics persists in a subacute form for 4 to 6 months after birth, with a peak in symptoms at around 6 weeks of age. Abstinence symptoms in the neonate exposed to nonnarcotic drugs in utero have been described for phenobarbital, diazepam, marijuana, and alcohol. Although withdrawal from these substances does not appear to result in as severe a syndrome of abstinence as withdrawal from narcotics, the newborn does exhibit the irritability and restlessness, poor feeding, crying and impaired neurobehavioral abilities that are characteristic of the neonatal abstinence syndrome.

The major problems facing child care workers today are associated with cocaine use in pregnancy. As in other substance-abusing populations, cocaine-addicted pregnant women have a high incidence of infectious disease complications, especially hepatitis, AIDS, and venereal disease. There is an increase in complications of labor and delivery in cocaine-using women so that precipitous delivery, abruptio placentae (usually occurring shortly after administration of cocaine), evidence of fetal monitor abnormalities, and fetal meconium staining are present in a significant number of pregnancies complicated by cocaine use. Gestational age tends to be lower for cocaine-exposed infants, and neonatal birth weight, length, and head circumference smaller when compared to growth parameters for drug-free infants. Signs of irritability and tremulousness, with an inability to respond appropriately to stimulation are often noted in cocaine-exposed neonates. The neurobehavioral changes for cocaine-exposed infants are in some areas more severe than changes noted for methadone-exposed infants.

Many of the abnormal characteristics seen in the cocaine-exposed newborn persist through at least 4 months of age. When comparing motor development of cocaine-exposed infants to non-drug exposed infants, some striking differences can be noted in muscle tone, reflexes, and movement patterns. Many cocaine-exposed infants feel stiff when their limbs are moved, and on their back often lie in excessively extended postures. Tremors are common, especially in their arms and hands, when they reach for objects.

A high rate of complications have been noted for cocaine-exposed neonates. Perinatal cerebral infarctions (strokes) have occurred in infants whose mothers have used cocaine over the few days prior to delivery. These perinatal cerebral infarctions are a severe example of the morbidity associated with intrauterine exposure to cocaine and are similar to strokes reported in adults who use cocaine. There is also evidence for genitourinary, cardiac and central nervous system malformations in infants delivered to cocaine-using mothers. Abnormalities of respiratory control, with an increase in infant apnea, have been noted in clinical studies. Most published studies of cocaine's effect on pregnancy and infant outcome have focused on recognized substance-abusing populations, and little information regarding the effects of minimal cocaine use is available.

A recent study by our group published in the Journal of the American Medical Association documented the efficacy of our early intervention model. In this study, we documented that cocaine using pregnant women who, through comprehensive medical and psychotherapeutic intervention became drug-free by the end of the first trimester of pregnancy, had a lower rate of complications in pregnancy. Specifically, successful intervention resulted in a lower rate of spontaneous abortion, premature delivery, intrauterine growth retardation, and abruptio placentae. Infants born to mothers who stopped using cocaine by the end of the first trimester had a lower rate of neonatal seizures and cardiovascular accidents. It is thus clear that the key to intervention is early recognition of the pregnant substance-abusing woman and prompt referral into substance abuse treatment.

Follow-up of cocaine - exposed infants has shown that although their general development is within the normal range, they show deficit at two years of age in attention concentration and language.

IMPLICATIONS FOR FEDERAL POLICY

Federal policy providing prevention and intervention approaches to the problems of alcohol and other drug use in pregnancy should be based on three basic concepts:

1) Early identification of the pregnant substance-abusing woman and provision of treatment services to bring her to drug abstinence will prevent the obstetric and neonatal complications of perinatal addiction.

2) The most commonly missed diagnosis in obstetric and pediatric medicine is drug use in pregnancy; thus, necessary intervention is never initiated.

3) Even if the diagnosis of drug use during pregnancy is made, the physicians often cannot find an appropriate treatment program that will enroll a pregnant woman.

In order to address these basic issues, models of coordinated prevention/intervention services must be developed. These services should be based on solid research information and tested through demonstration projects with full evaluation of outcome. These projects cost money; however, these monies would fall far short of the $3 billion needed to provide care for these children after delivery in the first month of life.

I had the opportunity to participate in the review of demonstration program applications submitted to the Office of Substance Abuse Prevention in answer to their request for proposals to develop programs for substance abusing pregnant and post-partum women. Applications were submitted by community, county and state governmental agencies as well as health care organizations. A total of $35 million in requests was made, however, OSAP had only $4.5 million available to fund these programs. The level of frustration among front line health care workers is monumental. The answer lies not in developing newer, larger, and more expensive high-tech neonatal nurseries, but to begin funding prevention and intervention programs and developing health care systems that will answer the needs of the highest risk populations. The key to intervention will be access to health care for high risk women. Thus, physicians and other health care professionals must be trained to identify substance-abusing pregnant women and initiate referral into the treatment system. The public must be assured of non-punitive, comprehensive care which will meet the needs of the pregnant woman who is a substance abuser. We need not legislate health care and we need not resort to legal and punitive action if we look upon the pregnant women as a special category of substance abusers rather than a special category of parents.

Senator COATS. Amy?

Ms. WHEATON. Good afternoon, Mr. Chairman. I am honored to be here.

Senator COATS. Dr. Amy Wheaton is commissioner for the Department of Children and Youth Services in Connecticut.

You are also here representing the Child Welfare League's chemical dependency steering committee, which I gather is having a symposium?

Ms. WHEATON. Institute, this weekend.

Senator COATS. This weekend. We thank you for wearing, really it's one hat, in a sense.

Ms. WHEATON. It's one hat, and I also have a third hat on, which is that I am also a member of the American Public Welfare Association's national commission on child welfare and family preservation, which is obviously the issue of substance abuse among pregnant women as well as among parents is a consideration for that group as well.

Senator COATS. Thank you for being here.

Ms. WHEATON. It's a pleasure to be here.

I will like very briefly to talk about the impact of substance abuse among pregnant women and among parents on the child welfare system. I would then like to raise three of the more basic, in my judgment the most basic, policy questions that we face today in child welfare, and specifically child protective services. And finally I would like to make some rather radical suggestions for a forum.

Senator COATS. We would be disappointed if you didn't. [Laughter.]

Ms. WHEATON. I sort of feel like I am set up here today. But I am very happy to be here.

The way that I describe what has been happening in the last five years in child welfare is that I and my colleagues are operating emergency rooms. Child welfare organizations and public child welfare, including, notably, child protective service systems, have become the agency of last resort for abused, neglected, abandoned, damaged children.

Part of this, I think, substance abuse among parents, is the more recent and grim addition to some other factors. But let me talk first about poverty to which several Senators and some of the witnesses have alluded.

Poverty is more than just a lack of income. And we see it in the children whom we must place in foster care. Poverty is hunger. Twenty-five percent of the children in one neighborhood in a city in Connecticut, the wealthiest State in the Nation, are either chronically hungry or at severe risk of being chronically hungry.

If you are a child between the ages of one and 11 and you and your family have no home and you are chronically hungry, your health suffers as well. And how do you suppose your parents feel about their competency to parent you? Where is their self-esteem and their pride? What is their level of stress? Where is their support system? And where is there anyone who cares?

So before we move to the epidemic of substance abuse and its impact, I would simply want you to note that a pediatrician following children who enter foster care in the State of Connecticut for the past several years will tell you that children who enter foster

care are two or three times more likely to be short in stature, which is the most obvious symptom of malnutrition. They are two or three times more likely to have chronic or acute medical illnesses, have visual problems, hearing problems, speech problems, language problems, and cognitive problems. When our system receives such a child and places it with a foster family, what is that child's chance?

So I will tell you that protective services feels like an emergency room because of the enormity and trauma and severity of the problems that the children entering our system face. The impact of substance abuse among parents threatens to overwhelm an already overloaded system.

The policy questions: I will say less about the substance abuse, since most of the testimony has been about that and has been quite factual, even though we don't really have much prevalence or accurate incidence data yet. We hopefully will. I will turn my attention to the policy questions.

I think that one of the most difficult questions that a child protective service worker faces is how do they achieve a balance between the right of the infant or child to be protected from serious harm, and how do they balance that against the parent's right for privacy and their own knowledge and experience that to preserve the family and keep the family unit intact is the best thing that they can do for that infant or child?

It is a constant dilemma and is exacerbated by substance-exposed infants. The fundamental question I think that every protective service worker bears in the back of their minds and hearts is, "Who is responsible for the substance-exposed infant? Is it in fact just the mother? Is there access to health care, in fact, for these mothers?"

Dr. Chasnoff has suggested no, and I would confirm that.

And the word on the streets in Connecticut and in other cities is that if you are pregnant and you are abusing substances, for heaven's sakes, don't get prenatal care because they will threaten to take your baby.

You add to that the issue of a good many—we have talked about the saturation of information on the effect of substances on an infant if used by a mother who is pregnant. I will tell you the information is not reaching the women who are pregnant and are abusing substances. On the streets, a baby shower is an occasion for friends of the mother to bring crack to celebrate the upcoming birth and in fact to precipitate it.

And I have met mothers who have given up alcohol because it would injure the baby they were carrying, and they had not the slightest idea that crack was at least as serious a chemical to put into their body.

So I would submit that when we look at the issue of what is the degree of risk to a child whom we are considering removing from the mother, that we need to look long and hard at whether there are alternative supports that we can put into that home to guarantee the safety of the child and try to put that family back together again.

I will tell you that any child who has bonded with their mother and whom we remove, we know we are, at the point of removal,

damaging that child emotionally forever. A 12-year-old, a 5-year veteran of foster care, remarked, they said, "My mom couldn't take care of me. I said she was good enough for me." Every child in foster care waits for the day when their mom and dad will come up to that house and take them back home.

What I am suggesting to you is that from a child welfare and protective services perspective, we need to be very cautious about balancing the risk to the child of serious harm and the risk to the child's emotional stability of precipitously removing that child because of a positive toxicology screening alone.

There must be ample evidence that there is no other support system that can be introduced to enable that child to stay with that family.

The second difficult policy issue for me is that of the fragile foster care system. Senator Dodd has spoken eloquently. I would simply reference that children entering foster care, again through Dr. Simms in Waterbury, 60 percent of them are developmentally delayed, 40 percent have serious emotional disturbance, 35 percent have acute chronic medical problems.

What that says is that we need to be attentive about the special training and special supports that we offer foster parents who are taking very damaged and very troubled and very medically needy youngsters.

The final policy question for me is whether we are going to regard substance abuse particularly among pregnant women as a major public health issue or we are going to regard it, at whatever level, as part of the war on drugs.

Clearly, there are various approximations of being punitive. I think when we talk about a war on drugs, we didn't have pregnant mothers in mind. But there are various levels of being punitive. If you should elect to consider mandatory treatment for mothers for substance abuse, I would strongly urge you to consider mandating as well that that treatment be provided in an environment where their children can be cared for properly and well and, if necessary, attend public school.

You ask any mother how they feel when you mandate substance abuse treatment for their good and that of their children and their family, but, "No, you may not see and you certainly may not live with your children until you are free." I think that is punitive. I think it's felt as punitive.

It also is punitive to the child because if you remove the mother from a child, the child doesn't understand that cognitively unless they are at least six. They are going off to get well, you tell the child. Very difficult.

So I think we need to be very careful as we postulate policies, services, that we search our own souls and hearts and experience to ask what will or won't be punitive.

Finally, I would like to very briefly talk about the implications for human services delivery systems. Four basic observations:

One is that I was stunned when I read a little clip in a national magazine that a commissioner of corrections in a Midwestern State was very troubled at the inability to correctly and accurately project the number of prison beds needed in his State and, further,

felt better about his inadequacy by the fact that there were equally poor projections in other States.

Well, he finally decided that the most rational and reliable way to predict the need for prison beds in his State was to identify through the public schools children in the second grade who were at risk because the high probability was that they would end up in prison.

The striking thing about that for me is where is our investment strategy? On the one hand we have homeless families, on the other hand we are building prison beds. On the one hand we can identify children in the second grade—and I will tell you they can be identified when they are three years old—and yet we are waiting to invest our money in prison beds rather than in our children.

Second, perspective. Human services system forever have addressed the half-empty portion of this glass. It is called needs assessments. And we do it systematically and thoroughly and consistently. What I think we need to think about for a change is the part of this glass that is half full. I have never met a parent who intended to hurt their child. I have met a great many parents who have severely damaged their children by their own hands.

When are we going to connect with the parent's capacity and desire and deep-seated need to be a competent parent? I would submit to you that parenting is the most awesome responsibility in the world, and most of us have learned it lasts a lifetime, and yet none of us are prepared to be a parent. And if you are in poverty and you are isolated and you have no health care and you get this child that you can hold in one hand and it screams, even if you have an M.D. or Ph.D., you are intimidated. You do not know what to do.

Where is our investment in supporting parents' capacity—even the substance-abusing parent—their capacity and desire?

Finally, there is much talk—and it has gone on forever—about fragmented services. I would submit to you that fragmented services are a predictable and logical outcome of categorical funding. So when we in Connecticut process in 18 months examining reform of the child welfare system and human service system in some respects, when five commissioners sat down with two legislators and two superior court judges of juvenile matters and family matters and said, "What happens to families who are having trouble?"

Well, you know what happens? They have a case manager who goes into the apartment or the flat or the project and they look at the grandmother, who just came out of the hospital, and then another case manager shows up at the same kitchen table to find out if the infant has been to the well-baby clinic. And we have discovered that these families had as many as five or six people walking through their kitchen, each of whom thought that they had the treatment plan. Well, you know what? Every case manager was looking at one piece of one member of the family.

Reform will happen when we join in collaboratives. A couple of simple principles: Children thrive and grow best when they are in their family or in a permanent family home. It may well be adoption.

Families live in a community. If you ask any of us where we're from, the first thing we will say is the town in which we live. That

is where the rhythms, the sights, the sounds, that's where our identity is. And families, the communities in which they live, where are the stakeholders? Why all of a sudden does protective services inherit the child when the home is burned and the child is near dead? Where are the other stakeholders?

I would submit to you that we need to invest in assuring that every child is born wanted and well. That means education, that means access to health care. I would submit that we need parent ed and family support centers where parents can go not because they have a problem, but because they are a parent and that's an awesome responsibility.

I would submit that we need community case management systems where there is one case manager who deals with the family and all of the problems, who has priority access to every community service and every State service in that community.

I would submit that we need to invest in intensive family preservation and then in the other investments as well in terms of substance abuse. I think if we are going to offer, as you said, Senator, very eloquently, on demand substance abuse treatment, be that outpatient, day treatment, or residential, if it is to be day treatment or residential, it needs to include the children.

Thank you very much.

[The prepared statement of Ms. Wheaton follows:]

PREPARED STATEMENT OF AMY B. WHEATON

Good afternoon, Senator Dodd and members of the sub committee. My name is Amy B. Wheaton and I am Commissioner of the Connecticut Department of Children and Youth Services, the state's consolidated agency for children and their families. The agency is responsible for providing juvenile justice and child mental health services, as well as child welfare services. I also am privileged to be a member of the Child Welfare League of America's North American Chemical Dependency Steering Committee and of the American Public Welfare Association's National Committee on Child Welfare and Family Preservation.

I would like to commend you, Senator Dodd, and the members of this sub committee for focusing attention on the effect of parental substance abuse on children. It is a tragic problem that receives little public notice against the sensational backdrop of drug related murders, arrests, property confiscations and trials. But the problem is real, and is becoming increasingly severe.

I would like to discuss the impact of this problem on the child welfare system, highlight some of the policy questions raised by the

problem, and suggest some implications for human service delivery systems.

PROBLEM OVERVIEW

National studies reveal that 375,000 new borns are affected by their mother's substance abuse. This figure represents 11% of all live births. And the number does not include alcohol abuse during pregnancy.

Applying this percentage to the Connecticut birth rate, it is predicted that 5,000 children will be affected by their mother's substance abuse in this small state alone. In addition, in Connecticut it is expected that 420 infants will be born HIV positive this year, a particularly gruesome symptom of the drug plague. Add to these children those who suffer abuse, neglect and deprivation of basic essentials because of active drug abuse by their parents, and you have a picture that is decidedly grim.

These infants and children are truly victims in the word's most basic sense - they never even have a chance to "just say no" to drugs or "yes" to life.

In a letter to President Bush, former HHS Secretary Richard Schweiker, speaking of cocaine abuse, pointed out that "the public health problem we are facing today kills seven times more neonates every year than the total number who died at the height of the polio

epidemic. Yet there is no sense of outrage surrounding this preventable tragedy!"

Perhaps the most ominous statistic for child welfare officials is that in some neighborhoods, female cocaine users outnumber males for the first time. According to the Department of Justice, the number of women arrested for crack related offenses exceeded that of men in New York, Washington, Kansas City, and Portland.

Nationally, since 1976 reports of child abuse and neglect have increased by more than 300%. In 1987, state child welfare agencies investigated 2.2 million reports and confirmed maltreatment in 1.1 million cases. It is estimated that 40 to 75% of these reports involve allegations of substance abuse by the parent.

In Connecticut, since 1983, a period that roughly parallels the emergence of cocaine and its deadly derivative, "crack," as a major factor in the drug scene, investigations of child abuse and neglect increased by 50% - from 8842 in 1983 to 13,090 in 1989. Over 20,000 children were involved in child abuse and neglect investigations in fiscal year 1989, up from just over 13,000 in 1983.

The landscape of child welfare services has changed dramatically in the last decade. It has become the system of last resort for children who have been abused or neglected by their parents. These families often live in poverty. They face homelessness and hunger, have

little or no medical care, and are surrounded by violence in their neighborhoods.

The child welfare system, overloaded by these problems, is overwhelmed by the troubling and complex ramifications of substance abuse among pregnant women and parents. These range from family violence to serious physical and mental health problems, developmental disabilities and "boarder babies" abandoned in hospitals.

POLICY QUESTIONS

The impact of substance abuse by pregnant women and parents on infants and children and, therefore, on child welfare systems raises a host of significant and complicated policy questions for public child welfare agencies. I will note a few of the most anguishing questions. (Attached to my testimony you will find the full range of questions being addressed by the CWLA's ~~Chemical~~ Dependency Steering ~~Committee~~.)

One of the most troubling policy questions confronting public child welfare agencies is the existence of compelling and conflicting mandates. On the one hand, we are mandated to protect children from serious harm; on the other hand, we are mandated to respect the parent's right to privacy and to preserve the family as an intact unit. This is the awesome responsibility borne by every child protective services worker. Each worker who has heard the piercing,

inconsolable cries, watched the seemingly endless tremors, and seen the rigid, arching postures of a crack exposed infant knows the exhaustion, the worry, the deep inadequacy that the mother will feel in trying to care for her infant. Will she be equal to it? Will the infant be nurtured, fed, and otherwise cared for adequately? Will the mother be able to overcome her dependency on drugs? The worker will examine all the risks and bear the weight of knowing the vast importance of bonding for the infant's already fragile physical, emotional and social well-being. The enormity of the responsiblity of determining the mother's capacity to parent the infant is staggering. The decision will be a major watershed in the infant's life.

The decision is equally difficult when it involves a toddler or even an older child who has been abused or seriously neglected as a result of the parent's substance abuse. Case workers worry about the emotional price children pay when placed with families other than their own. Let there be no misunderstanding of this basic truth: No child can be removed from his family without suffering emotionally. Feelings of guilt, anger, fear and mistrust are overwhelming and tend to last a lifetime. As one 12 year-old, five year veteran of foster care, remarked: "They said my mom couldn't take care of me - I said she was good enough for me!" No substitute family, however devoted, can overcome a child's deeply held hope that - one day - his real mom and dad will show up and take him back home. This reality haunts every child protective services case worker.

It is easier to protect the child for the moment by removing him from the at risk situation. However, as I have indicated, out of home placement creates a different set of problems for children. Is an assurance of physical safety more important than long term emotional stability? At the point of intervention, without the benefit of hindsight, this is not an easy question to answer. Further, treatment of drug abuse is a protracted process, one that often is marked by months of progress followed by tragic relapses. A child can wait a long time in foster care while agency staff and judicial authorities try to determine whether the addicted parent in treatment can ever be considered responsible enough to care for him. This time period is critical for infants who will bond with their primary caretaker and for older children who become more uncertain about their future with each passing month. Time is especially poignant for a child because, to a child, one day seems like an eternity.

A FRAGILE FOSTER CARE SYSTEM

If, after a thorough review of the child's needs and the parent's capacities, a case worker decides that the infant or child will be at serious risk if he continues to live with his family, another troublesome issue arises: Where will the child be placed? The foster care system is, at best, fragile in every state in the country. Changing demographics and other factors have made it much more difficult to recruit foster families.

Ironically, most of the foster parents with whom I talk do not feel that they are special - just folks who are willing to look after youngsters who are in need of a caring home. But they are special. How many among us can see our way clear to disrupt our family constellation by taking in a frightened, confused and troubled child, and give enough care and attention to make him feel a part of us - and then let him go just when the adustment seems complete, because it is in his best interst to grow up with his family of origin or a substitute permanent family? Probably not many of us. But I am confident that you share with me the extreme sense of gratitude that I feel when I reflect on the services that foster families provide.

Yet we show our gratitude in strange ways. Often the reimbursement for foster care is much less than the USDA standard for raising a child, the training is less than appropriate to the complex needs of the children in care, and the support systems (e.g. respite care, day care, clinical consultation) are non-existent.

A "WAR" ON DRUGS, OR A BROADER PUBLIC HEALTH INITIATIVE?

A final major policy question related to the problem of substance abusing pregnant women and parents is what our public policy will be.

There appears to be growing support to include this problem in our nation's overall "war" on drugs. While I find this sentiment

children of parental substance abuse, I am not sure that this body, or the American public, really wants to declare war on pregnant women. For such a war, which by definition would be punitive in nature, would result - as do all wars - in civilian casualties, in this case children who already have been victimized once by the drug problem.

Punitive measures, or measures that give the appearance of the threat of punishment, tend to have outcomes the opposite of their intent. For example, pregnant women will hide at all costs their drug addiction, even to the extent of forgoing pre-natal care and delivering their babies at home, if they believe that by admitting to a problem they will lose their child. The result is fewer women getting vital pre-natal care, more low birth weight babies, higher infant mortality rates and, of course, non-identification of a drug related problem that otherwise could have been treated.

In the most general sense, I believe that the issue of substance abusing pregnant women must be addressed as a serious public health issue rather than as a criminal matter that can be eliminated through punitive measures. The grip that drugs have on our society is too firm to be frightened away by the threat of punishment. Instead we must seek to educate, treat, and create the conditions in which mothers can care for their children while remaining drug free.

DANGEROUS MISINFORMATION

While it would seem to the average observer that the amount of information on the destructive effects of drug use is at the point of over saturation, it is a fact that literally thousands of young women believe that using cocaine during pregnancy will result in easier delivery. These women actually believe that cocaine ingestion during their pregnancy is beneficial! As hard as such "reasoning" is for us to fathom, we must remember that in a large number of cases these are children having children. They usually don't read newspapers regularly. Many have dropped out of school. They certainly do not have access to the latest report of the surgeon general on the consequences of drug abuse on a fetus. Obviously we need to find new ways to spread the truth about drug abuse during pregnancy: That you will hurt your unborn child; your baby may be born with serious defects; your baby may die!

IMPLICATIONS FOR HUMAN SERVICES

Clearly the impact that parental substance abuse, particularly that of pregnant women, has on our children presents us with a challenge of epic proportions. I have described a few of the basic problems and significant policy questions that the issue causes for child welfare systems; with your permission I would like to suggest some implications for human service delivery systems.

The impact on infants and children of substance abuse by pregnant women and parents is devastating. The impact on child welfare

systems is overwhelming. The magnitude of the problem is so great that two prominent national organizations - the APWA and the CWLA - are concentrating on developing proposals to address the problem.

At least two implications for human services delivery are clear, I believe.

First, if we know that these problems exist, why do we wait until a crisis for children and mothers occurs before we address them? Why do we wait until the financial - and human - costs are extraordinary? Second, the expertise required to address these problems cross many disciplines and service delivery systems.

These two implications translate, I think, to a need for major changes in the services we offer, as well as reform in the way we deliver them.

"An ounce of prevention is worth a pound of cure," and it costs far less. I believe that we need to invest in prevention strategies that will focus on assuring that every infant is born wanted and well. Further, we need to invest in strengthening parents' capacities to protect, nurture and support the healthy development of their children.

Finally, we need to join with local stakeholders - elected officials, businesses, churches, community groups, foundations and civic organizations - to develop child centered, family focused services

that are home and community based. We must develop collaboratives or partnerships that coalesce the special areas of professional expertise in child development, health, mental health, education, child welfare, housing, alcohol and drug treatment, and public welfare.

PREVENTION

Parent education and family support centers, located in neighborhoods in all of our cities, could provide high quality pre- and peri-natal education for young mothers as well as linking them with important medical care resources and with other parents. Such centers could do so without imposing a stigma of being an "unfit mother" or requiring the intervention of state child welfare authorities. Mothers and fathers could obtain important guidance and training in parenting skills and child development, thus reducing abuse and neglect due to lack of information and experience.

COMMUNITY CASE MANAGEMENT

Families who are in need of services should be able to get them with the least amount of wasteful bureaucratic overlap as possible. Imagine the embarassment and frustration of a young, drug addicted mother trying to explain her situation over and over again to several different workers who then set out to provide treatment in ways that conflict, confuse and generally don't work well. Community case management systems would provide one case manager for the

family who will make an overall assessment of the situation, and devise a plan that will address the entire picture of all the family members and their needs rather than several different parts separately. By having broad authority to access services across agency lines, a case manager can develop a realistic plan to enable the family to gain control of their own situation, thus reducing their dependency on state agencies to solve problems for them. Substance abusing parents served by such a system can then make a free and informed choice as to whether they wish to make the fundamental changes necessary to keep their families intact.

INTENSIVE HOME BASED SERVICES

Even if we can put in place new and effective education and treatment programs from a child protection standpoint, we still will have to deal with many substance abusing parents who, because of their addiction and other stresses, abuse and neglect their children. Because these are among the most confounding cases to treat, bold new strategies are called for in approaching them. I submit that we cannot continue to rely on traditional methods of providing services to these families, including the almost exclusive reliance on removing children from at risk situations and placing them in foster care. Although federal law and state regulations require us to keep families together whenever possible while providing services, until recently this was an ideal that was difficult to attain, particulary in families where drug abuse is a factor. However, we know now that programs such as Intensive Family Preservation Services can be

a remarkably effective tool in which to help parents solve their problems and become effective caretakers of their children.

Intensive Family Preservation programs assign a highly-skilled caseworker to work with a family in which there is imminent risk of having a child removed from the home due to abuse or neglect. The caseworker focuses on the entire family, often replacing two or three other workers who, in traditional service delivery models, tend to focus on individual family members. The services are delivered in the family home and community as opposed to traditional office visits. By visiting the home the worker can observe family dynamics and assist the family members in correcting dysfunctional behaviors as they occur. Besides being a powerful assessment tool, the act of providing services in the home gives the family a feeling of being "in charge" of its destiny and is a clear indication of the respect the social worker has for the family.

Intensive family preservation programs recognize that it is the family's responsibility to raise their own children. The state's role should be to help families meet their responsibilities. There is considerable research which shows that long term savings - in both economic and human terms - can be realized by their implementation.

FRESH APPROACHES TO DRUG TREATMENT NEEDED FOR WOMEN

We know, however, that education, prevention and family preservation services will not be enough given present realities. Crack is known to be so powerful that one or two experiments with it is enough to "hook" a person permanently. Expanded access to a continuum of treatment programs for all addicted persons, and especially pregnant women and mothers, is absolutely essential.

In Connecticut, child advocates are calling for priority access for pregnant women into drug treatment programs. This is an attractive measure that is being tried in some states, Maryland for one, and may have some promise. But the fact is that drug treatment facilities are already stressed to the limit, and the added burden of having to program for pregnant women, (increased need for medical care is one of the biggest barriers), may be more than the existing system can handle.

Can it be possible though, given the enormity of this issue and the terrible problems it causes for the most innocent and vulnerable victims, infants, that we can be so bold as to envision a new array of drug treatment programs just for pregnant women and women with new born infants? There is no doubt that such a strategy would be expensive, but when we consider that in these programs we would be treating two people for every one identified addict, and one of them is a defenseless child, do we have any other choice but to make bold moves?

Treatment centers for addicted pregnant women and mothers would require attention to medical needs as well as addiction. They would have to be able to accommodate infants and toddlers so that their needs for bonding and medical treatment could be met. They would require comprehensive follow-up programs designed to help mothers remain drug free and able to nurture their children.

COMPREHENSIVE CONTINUUM NEEDED

In summary, I submit that there is a comprehensive continuum that, taken together, address many of the concerns that I have voiced. The continuum would begin with effective drug education prgrams, pre-natal care and education, peri-natal care, education and support, home-based treatment programs, out-patient substance abuse treatment, extended day substance abuse treatment programs for mothers and children, and residential substance abuse treatment specifically for pregnant women and mothers with accomodations for their children.

SYSTEM REFORM NEEDED

To establish a continuum that would be meaningful, reform - rather than repair - of the service delivery system is necessary. Middle and upper income families who are referred for abuse or neglect can generally be helped successfully by traditional forms of treatment. They have insurance, support systems and a reasonable income. Families in poverty, on the other hand, generally exhibit multiple

problems that are responded to by workers from several different agencies. Each discipline is inclined to approach one family member from the particular perspective reflecting its department's mandate. The drug specialist responds to a substance abuse problem; the child protection worker attempts to assure the safety of the children, Income Maintenance workers provide financial assistance; and so on. Thus a poor family may have as many as four or five caseworkers and an equal number of "treatment plans."

Predictably, the sum of the parts of such a system is seldom enough to make the family whole and functional. A drug addicted single mother may take advantage of in-patient treatment, but as a result lose her AFDC because she is no longer living with her children. If the child welfare agency has placed her children in foster care she cannot get them back unless she has a place to live. And she can't rent an apartment without AFDC.

And so it goes. Families are shattered, reunited, and shattered again in spite of, and sometimes because of, a categorical human service system's best efforts to help.

Meanwhile, children are being hurt physically and emotionally. Children are being born drug addicted and HIV positive. Children are showing up at school or in emergency rooms with unexplained bruises and broken bones. Children are being neglected to the extent that their lives are endangered. Children are dying. The best possible intervention won't change for these children the fact that

they have already felt the lash, it can only bandage the wounds and try once again to assure that things won't get worse.

With the stakes for children so high, a categorical service delivery system designed to treat symptoms rather than prevent problems is a breach of trust. The nation's children deserve far better. And as child abuse and neglect is so prevelant in areas of high poverty, it cannot be treated or prevented in a vacuum. The problems are inextricably connected and cannot be solved by a single agency, nor by government acting independently of the other sectors of our cities, state and nation.

As public policy makers, you are faced with a task of olympian proportions. What I and others are suggesting as solutions to the grave problems that the drug scourge is causing for our children will require significant new funds. And it will take political courage to resist those who would take the more direct route of declaring "war" on the problem. It is easy to become angry with substance abusing parents and remove their children as punishment for their behavior. But as I have pointed out, the children, who are victims once when they are born drug exposed, or who are abused or neglected as a result of their parent's drug use, become victims once again when such strategies are employed. We must shift our thinking on the issue to the long term, to solutions that take into consideration the need for children to grow up as a part of their own family whenever possible, and to solutions that recognize the abuse of drugs in our

society is a major public health issue that cannot be wished away by telling pregnant women and parents to "just say no."

It seems to me that a message that says to young women "If you are pregnant and addicted to drugs, come to us and we will help you" is eminently more effective than one that says "we will take your baby away if we catch you."

Problems of the proportion of the one that we are attempting to understand here today require boldness, innovation and courage to solve. We are at a watershed in the history of child welfare. We can decide either to continue to add pieces to the present system which is overwhelmed by the drug abuse of parents and pregnant women, or we can decide to strike out in bold new directions in the hope of finding effective methods of dealing with the problem that is causing such severe and lasting emotional and physical pain for our children.

I recommend strongly the latter option.

Thank you.

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HIGHLIGHTS AND QUESTIONS FROM THE WORKING PAPER ON CHEMICAL DEPENDENCY FROM THE CHILD WELFARE LEAGUE OF AMERICA, INC.

Prepared by Charlotte McCullough

The U.S. has the highest level of illicit drug use by young people in any industrialized nation in the world, and drug use initiation is occurring at an earlier age than ever before.

When the trends are examined racial, cultural, and gender differences emerge in the types of drugs used and in the consumption patterns. While chemical dependency cuts across all social, economic and racial lines, there is a disproportionately high rate of abuse in the populations of color. There are many different theories to account for this and each theory has implications for prevention, intervention, and treatment. One can approach chemical dependency as a symptom of underlying societal ills; or, one can view dependency as a "disease" or pathology of the individual.

The latest NIDA survey indicates that casual use by adolescents has declined in the past four years; while the heavy use of cocaine has risen. And, while alcohol use has declined slightly, there are still six times more alcohol abusers than cocaine users. What these findings mean regarding the effectiveness of our current public education and prevention efforts is debatable. It has been interpreted to mean that we are succeeding in reaching and educating those middle class adolescents who are still in school, and who may not yet have used drugs; but, we are failing to reach the high risk population--the school failures, the disenfranchised underclass, or the individual who has already become a polydrug user.

IMPACT OF CHEMICAL DEPENDENCY ON THE INDIVIDUAL

A large body of research exists which documents the physical and emotional toll of dependency on the individual. We know that one quarter to one half of the children of alcoholics will become alcoholics. We know that alcohol use during pregnancy can lead to FAE, and FAS, which are among the top three birth defects in this country. We know that the majority of high school seniors define themselves as "drinkers." We know that, while the use of marijuana is not on the increase, the potency of the drug is. We are now concerned that this "harmless" drug of the sixties, may actually cause both short and long term memory and concentration problems. In addition, many experts argue that both alcohol and marijuana are "gateway drugs" which precede the use and abuse of other drugs. We know that cocaine is the most powerfully addictive drug on the scene today, and because it is now inexpensive in the form of crack, it is considered the number one drug problem. In the past five years, perinatal exposure to cocaine has far surpassed exposure to heroin, PCP, or amphetamines. The long term effects on the drug exposed infant. are not known, but preliminary findings suggest that physical, emotional, and development problems can be found in school age children. We know that crack has disproportionately devastated minority communities, with Hispanic youth showing the highest increase. We know that the use of heroin has not increased, but of all the illegal drugs, it is still responsible for the most deaths. The use of PCP, amphetamines, inhalants, barbiturates, and "designer drugs" (ice, etc.), is not increasing, but remains

at a constant, unacceptably high level among adolescents. In addition, we know that most users are polydrug users, and their drug of choice is whatever is available and/or cheap on a given day. Each week, in all regions of the country, a new drug or a different combination of existing drugs emerges as a new threat.

PREVENTION STRATEGIES

Over the past decade, we have seen a shift from the school based prevention model to a broader community based approach. In addition, experts are calling for a different message that "Just Say No." Some are asking whether the focus should be on prevention of "use" or prevention of "abuse."

QUESTIONS:

1. What is the difference between use and abuse? According to OSAP, all use is abuse when the person is under 21. Others argue that it is this mentality that has hampered successful prevention efforts.

2. Is it normal experimentation for adolescents to try marijuana or a drink at a party? Or, is it pathological? Where do you draw the line?

3. Should prevention efforts target all drugs, or should efforts be directed to the "gateway drugs?" Or, to the more devastating drugs like crack?

4. Should consumption patterns be a factor? Do we reach the occasional user with the same message that we reach the chronic polydrug user?

5. If the desire is for a "menu" of strategies targeted to different populations of users, can we identify what elements are necessary for successful outcomes?

6. Many are calling for community based programs to address the role of cultural, and ethnic factors in planning prevention strategies. While locally designed and implemented programs seem to be better able to deliver the message, correct misinformation, and combat the "street wisdom," it isn't clear what the implications are for developing a "National" drug message. Is a national message necessary?

7. And, finally, the designers of prevention must recognize the institutionalized and individual economics which are supporting addiction. For example, large amounts of money are poured into advertising to attract the adolescent to alcohol, as witnessed by the success of the wine cooler campaign. And, unskilled poor youth are able to buy the American dream from the proceeds of drug sells. How can prevention efforts be successful when so many dollars are spent and made luring youth to use drugs or to deal them?

IMPACT OF CHEMICAL DEPENDENCY ON CHILD WELFARE

Chemical dependency has resulted in increased referrals to the child welfare system. As a result, an already overloaded system is now overwhelmed. There have been casualties of the system, as witnessed by the "Boarder baby" phenomena, where addiction by the mother is a factor in 69% of the cases.

The fastest growing population coming into the system are infants and children under six who are drug exposed, medically fragile, and/or have drug addicted parents. High caseloads have resulted in backlogs of uninvestigated cases for weeks or months. When intensive in-home services are provided to attempt to prevent placement, the effort is met with very limited success. In over 60% of the cases where the mother is unwilling or unable to get drug treatment, placement is necessary within the first year. When foster care is needed, there are delays due to the unavailability of foster homes trained or supported to manage these children with very complex needs. Some are calling for increased use of group homes as a long term option for those children not freed for adoption and with no other permanency options. When reunification is not possible and adoption is an option, additional supports and incentives are necessary to assure the success of the placement.

Adolescents entering the system today also present challenges not previously encountered by the child welfare system. There are various explanations offered to explain the

new "tougher kid," but the reality is that this population consists of more seriously disturbed, highly dysfunctional, frequently drug involved older youth. For many, foster home care is not available, or even desirable. However, the residential treatment centers attempting to serve this population are finding that the traditional approaches and interventions are not working. Many are just beginning to understand the role substance abuse has played in the behavior they see and they are seeking guidance to develop policies and programs to address chemical dependency.

In all areas of child welfare practice it is becoming apparent that the impact of chemical abuse must be addressed. In many cases, this means reevaluating existing policies and procedures and standards of practice in light of new knowledge about the realities of dealing with drug addicted youth and families. It may mean changing existing laws or proposing new legislation to protect the children and youth devastated by drugs. It certainly means training and supporting staff to better deal with the challenges they face on a day-to-day basis in today's world.

Following are examples how drugs are impacting child welfare services and some of the questions that must be answered:

Child Protective Services:

Recent research and anecdotal information suggests a high correlation between chemical use by the parent and family

violence. As many as 85% of the child protective service cases in some cities involve chemical abuse. In New York last year, 73% of child fatalities were related to parental substance abuse.

QUESTIONS:

1. At what point does substance abuse by a parent lead to the removal of the child from the home?

2. What methods should be used to monitor chemical use by parents know to have a problem?

3. Should parents be required to submit to drug testing? For what chemicals? Who should test? For what purpose?

4. Can alcohol, a legal substance, be prohibited if there is a link to child abuse?

5. What assessment/intervention methods should be used with children of chemically dependent parents?

6. Should parents be mandated to receive treatment in order to retain or regain custody of their children?

7. What additional training and support is needed for the CPS worker to better identify and understand chemical dependency?

8. What interagency collaborations are necessary to better serve this population?

Adolescent Pregnancy Services:

In spite of prevention efforts thus far, the numbers of teen addicts and teens giving birth continue to rise. Females now constitute almost half of the chemical abusing population, and over 90% of them are of childbearing age. In the majority of cases, adolescents coming to the attention of child welfare, have layers of problems in addition to their addiction, and pregnancy. They are frequently uneducated, unskilled, unemployed, with unstable or nonexistent housing. Many have illnesses or diseases associated with poverty or addiction. The pregnant addict who wants help has to overcome often insurmountable obstacles. For example, most drug treatment programs don't accept pregnant women, and most providers of prenatal care or adolescent pregnancy services don't screen for, understand,, or treat addiction. In addition, there is little or no coordination between the various agencies serving this population. Increased funding on a federal level; coordination on a local level; and research to determine what works best, have been called for.

QUESTIONS:

1. When a pregnant adolescent is identified or admits to chemical abuse, should this trigger a protective service intervention for her unborn child? For any other children she might already have?

2. Given the importance of early recognition and intervention of chemical use to minimize or prevent damage to the fetus, should the adolescent suspected of abuse undergo drug testing? Who should test? For what purpose? Who should be told?

3. If a drug screen is done, should a positive test be used to mandate treatment?

4. How should a suspected user be monitored during pregnancy?

5. Should an IV abuser be tested for the HIV infection?

6. What role does the adolescent's family have in regards to testing or monitoring?

7. How do we reconcile fetal rights vs. rights to privacy? There is a growing trend towards criminalization of women who use drugs during pregnancy. How far should the state go in protecting the "unborn child?"

8. What is the role of the hospital when the first indication of drug exposure occurs at the time of delivery? Should all suspected exposure result in a toxicology screen? Should the screen be for all drugs? Should the infant, the mother or both be tested? Who should decide to test? Who should the results be reported to? Should there be penalties for failure to report? Should there be immunity for good faith

reporting? Is a positive toxicology screen necessary, and/or sufficient for a referral to CPS? Should a positive screen trigger a screen for HIV as well? Should a positive test and or signs of withdrawal constitute prima facie evidence of abuse or neglect?

9. What specialized assessment tools are needed to determine the short and long term service needs of these drug exposed infants? Should these tools be developed by the child welfare community, the medical community, or both?

10. What specialized medical case management is required for these infants, and their mothers?

11. What should the criteria be for releasing the drug exposed infant to the mother?

12. How long should the case remain open after discharge from the hospital or a treatment facility?

13. What skills do adolescent pregnancy service providers need to be able to better identify chemical abuse and to better manage the case once identified?

14. What training is needed to assist adolescent pregnancy child welfare workers to develop the skills?

Foster Care Services for Drug Exposed Infants and Young Children:

As many as 60% of the drug exposed infants and children of nontreated addicts eventually wind up in foster care. The flooding of the system is resulting in 30% increase in foster children under 5, a dangerous overcrowding of foster homes, and a high rate of turnover, "foster care drift" for many of these children. We know that most of these children have a wide array of medical, developmental, and psychological problems. Thus far, our efforts to address these unique challenges drug exposed children present, have been inadequate.

QUESTIONS:

1. What are the long term effects of polydrug exposure, especially "crack" on a newborn and how does this impact placement planning and medical care? What other social services are these infants likely to need as they age?

2. How can foster parents be recruited, trained, and compensated to care for these children?

3. Given the difficulty in recruiting foster families, and the "drift" from one family to another, are group care settings a viable/preferable option for these medically fragile infants and children?

4. Research on the crack addicted mother is finding that the abuse seems to destroy the ability or desire to parent.

Will reunification of these children with their parents become less likely? If so, what long term care options or permanency plans must be developed?

5. What is the role of relatives in providing substitute care for the children of addicts? In light of research which indicates a pattern of chemical dependency in the families, are the relatives of addicts adequately screened for their own abuse?

6. How do children raised in foster homes compare with those raised in addictive parent homes?

In-Home Services to Prevent Placement:

There is heated debate regarding the appropriateness of in-home services for addicted parents unwilling to enter treatment. Even with intensive in-home supports, the majority of addicted mothers lose custody of their children. In addition to being at risk from neglect, the child is at risk from the violence inherent in many of the drug-infested communities.

QUESTIONS:

1. When should home-based crisis services be used with substance abusing families?

2. When should home-based services not be considered an option?

3. What additional precautions must be taken in protecting workers who are providing home-based services?

4. Should drug treatment be a condition of receiving home-based services?

5. Family preservation services have at times become endurance tests for the child. How long should the child have to wait for the addict to begin treatment or for out-of-home care to become an option?

Residential Treatment Services:

Many argue that the most effective treatment for the seriously chemically dependent is residential treatment. There are as many different treatment approaches as there are theories of addiction. At the same time, there are few well-designed research studies which clearly identify what works. Again, it depends on what the goal of treatment is. Is it abstinence? Is it managing to stay out of trouble? Is it learning how to use drugs more safely?

In treating the adolescent abusers, researchers are stressing the importance of connecting the whole family into the treatment process and using the peer group to help shape the desired behavior and attitudes. In treating the adolescent addict who is also a mother, residential treatment for the mother and infant has shown promise. The addict has the opportunity to deal with the chemical dependency while building parenting

skills. Advocates have called for increase funding and availability of treatment slots, and for research to document what is most effective.

QUESTIONS:

1. When should residential treatment be chosen over community-based outpatient programs which allow the adolescent to remain at home?

2. Should admission to a residential program be mandatory or voluntary?

3. Given the range of programs from confrontational to highly supportive, do we have any idea of what is most effective?

4. Should adolescent programs differ significantly from adult models? If so, how?

5. Should programs be specific to the drug abused? I.e., should alcohol, heroin, and pot abusers be treated alike?

6. How do we need to program for the multiple diagnosed youth? I.e., if the youth is engaged in delinquent acts, violent, acting out and drug involved, is drug treatment the first priority? How do residential drug treatment facilities manage the violent/suicidal youth? Are these youth best

managed by the child welfare community? Or, by mental health/substance abuse providers?

7. Is residential treatment for the addict mother and infant the best option? Who should provide these services, child welfare providers, substance abuse providers, or medical facilities?

8. Based on the limited research outcome data, what are the critical elements for a successful program?

Adoption Services:

In light of recent headlines focused on babies living and dying in crack houses and the estimates of thousands of children being born to and abandoned by addicted mothers, some believe efforts and laws to preserve the family have gone too far. Many call for protection of the child today and revision of existing adoption laws to more easily terminate parental rights.

QUESTIONS:

1. Should the reasonable efforts requirements of P.L. 96-272 be applicable to this population?

2. What should be the criteria for terminating parental rights?

3. Will the behavioral, medical problems of these children freed for adoption, create obstacles for successful

adoptions? If so, what supports/incentives are needed to recruit and support the adoptive parents?

4. Is the trend towards open adoption appropriate when placing drug exposed infants/children in adoptive homes?.

5. Should the adoptive family be informed of "suspected" prenatal exposure in the absence of a positive toxicology screen?

6. Are potential adoptive parents adequately screened for chemical dependency?

Day Care Services:

An estimated 36,000,000 children attend day care each day and as many as 70% of their families are involved with chemical substances.

QUESTIONS:

1. What staff training is needed to better identify children of substance abusing parents?

2. What are the legal implications of dismissing children to intoxicated parents?

3. What is the appropriate role of day care in prevention and treatment?

4. What should employee benefits and policies be for the chemically dependent day care staff?

5. What should be the relationship with the schools in designing prevention programs?

6. How can CPS departments, and day care agencies work together to improve referrals and reporting requirements?

Administrative Policies for All Child Welfare Agencies:

While it is beyond the scope of this paper to do an analysis of the impact of drugs on the workforce and on the child welfare field, in particular, administrators and boards of child welfare agencies should review their existing policies, procedures, and benefits packages to determine if they are supportive of employees who may have a substance abuse problem. The U.S. Department of Labor recently issued a monograph of, "Workplaces Without Drugs," which highlighted some of the ethical and legal issues involved in designing "drug free" environments and in instituting drug testing procedures.

Senator DODD. [presiding.] Thank you very much again, Amy. We appreciate your being here and your comments.

Let me just quickly ask a few questions. I know, Dr. Chasnoff, you have a meeting to be at as well. Let me just run down a couple of questions here quickly and turn to my colleague. Then, we may submit some additional questions to you as well.

Why don't you comment—because we had so much said by others on this punitive, involuntary/voluntary approach to addicted mothers, and we have heard Amy talk about it—why don't the two of you talk about it? What are your thoughts about it?

Dr. CHASNOFF. We talk out of the same sides of our mouths. It is clear that no matter what interventions are designed, the public will look upon them, if they are involved through child protection, the public will look upon them as punitive.

It is clear that when you begin identifying women during pregnancy and mandating them into prenatal treatment, you lose the women from prenatal health care.

The studies from the early' 70's show that even if a woman continued to use drugs, if she got prenatal health care she had improved pregnancy outcome.

Now, clearly, we want to give them prenatal health care plus get them off drugs. But what results when you start taking punitive steps is that you drive the women away from prenatal health care, so then you have babies born to women who not only use drugs but also had no prenatal health care. That is to the detriment of the child and to the family.

As we look at this situation, we have to look at the family as a family unit. We have to provide the kind of support for the women prenatally that we can train them to be good parents.

One of the things I keep hearing over and over, not only here but at the National Academy of Science meeting this morning, everyone is making the assumption that a woman who uses drugs cannot be a good mother. And I think that is an incorrect assumption to make. And as we begin to look at how to deal with these issues, we cannot rely on the foster care system or the welfare system to take over parenting. We have to find women prenatally—and men—and train them to be good parents, help them get off drugs and help them get ready for taking care of their own children.

Senator DODD. I said something a while ago to Dr. Kleber, and then I thought, well, I just assumed it was the case. I am not a doctor, so maybe I was wrong. In terms of the success rate of treatment programs whether they are mandated or they're voluntary, I suggested that the success rate was probably better in a voluntary program, given the desire of the person to be there. That was just an assumption on my part.

But am I incorrect in that?

Dr. CHASNOFF. Well, you're not right or wrong, because there are no data to support one side or the other. We have a lot of, looking at this from a purely research perspective, there are a lot of holes in the data. We don't know if mandatory treatment works or not. We don't know if taking children away from mothers and putting them into foster care works or not.

We have a study going on right now where we have a cohort of about 35 children who were born to cocaine-using women and who were adopted at two to three days of age. It's a long-term study. We should have our data ready in another six to nine months, looking at outcome to see if bringing a child into the adoptive middle-class home actually makes a difference in long-term outcome. We just don't know that yet.

Senator DODD. Yes.

The inspector general's report recommends focusing service strategies on serving the entire family. I think both of you described that. You got into that, the seamless garment idea that I have talked about a lot. This is one of the problems, it's hard to explain to people. I have been very complimentary and Senator Coats has been as well on the administration's commitment on Head Start, for instance, and on some of the nutrition programs. They are long overdue, but deeply appreciated.

The problem I have, and others may want to address this, is that you see a $757 million increase in funding for some of these programs, and if you look at the other ones like health and housing programs, you have a $2.6 billion cut. There isn't any such thing as the AFDC family and then the WIC family or the family that has housing needs. If they have one of those, you can almost be assured they have all of them.

The notion you have about a central location and so forth is important. So I guess in a sense you have sort of addressed my question about the importance of an integrated approach, unless, Doctor, you wanted to comment further.

Dr. CHASNOFF. No. I think they have said it.

Ms. WHEATON. The one observation that I would add to that, Senator, is that I think it's a question of whether you pay now or later and at what rate. And from my perspective, the costs that are outlined here are very real. If anything, over time they will probably be conservative. And if we don't intervene early, the children will go on being born and damaged and the costs, financial and human, will be extraordinary.

And this country, I would think, can least afford, of the civilized nations, not to assure that every child who is born is born well and with the opportunity of being successful.

Senator DODD. Yes.

Ms. WHEATON. Many are beginning to realize that.

Senator DODD. Well, we extrapolated a number of $100 billion. And that is just taking the numbers that come out of the study and moving them forward. But in fact, we cheated because the numbers actually, if you do pure math, come out much higher than $100 billion, but we figure that it's at least that number. If your numbers are correct on the 100,000 figure, we are looking over 10 years at costs that high. Math was never my strong point. [Laughter.]

But at Metropolitan Hospital where we were in New York, the pediatricians said that just in the IC unit, for those children from the moment of delivery, on the average, before they reach a weight that would allow them to go home, the cost is running $40,000 to $60,000 per infant. And then before that child reaches the age of two—and this is becoming one of the centers of concern because of the staggering percentage of children that are born as junkies—

that that child will have five to seven extended stays in that hospital before age two.

So you are starting to talk of numbers that get into the $100,000 range or more for that infant before age two.

Dr. CHASNOFF. But the key point here is that those costs are preventable. There is good evidence in the literature now, in the medical literature, that if you identify the cocaine-using pregnant woman, get her into treatment and off drugs, you prevent the low birthweight, you prevent the maturity, you prevent the seizures, you prevent on and on and on. So those babies go home in two days as opposed to an average of 21 days after delivery.

Senator DODD. Yes. You said something a minute ago, you said even if they don't stop using drugs and if they get in prenatal care, that you're able to have a——

Dr. CHASNOFF. That's from the early 1970's. Those studies were done with heroin-using women.

Senator DODD. Yes.

Dr. CHASNOFF. And even women who continued to use—we see three groups of women currently: We see women who come into treatment and are successful and become drug-free; we see women who come into treatment and continue to use; and then we see women who get no prenatal care, have used, and delivered. And it is clear that the women even who come into treatment and continue to use cocaine still have better perinatal outcomes than women who had no prenatal care.

So when people talk to me about issue that are going to drive women out of prenatal health care, I cringe because if we are looking, we have to establish what our goals are. If our goal is to get a woman drug-free during pregnancy, then maybe we should put her in jail because then—well, aside from the point that it's easier to get drugs in jail than out. [Laughter.]

But let's assume that we have the best of all worlds: We put her in jail and she becomes drug-free. She comes, she delivers, what do you do then? What is your long-term outcome?

I would rather see putting our skills and our money into programs that will effect long-term changes, and those changes are going to have to focus on family reunification, functional families, and drug treatment and training in the prenatal period so that long-term these kids are going to have a chance.

Senator DODD. That Odyssey House program, the one we went to in New York, I won't cite a statistic to you because I can't remember, but there was a very high success rate where the woman was in treatment with the child. Where they had the accommodations to provide for the parent and the child, they just had a tremendously high success rate in that kind of environment.

Another thing that was fascinating to watch was the number of men there in the drug treatment programs that were working with the children living there. I spent some time talking to some of these young fellows who had been heavy drug abusers who were feeding the children and so forth, learning parenting skills. It was moving to watch and just talk to them about what the experience had been like for them—these were not their own children—working with other residents' children in terms of the success of drug treatment.

So it is fascinating what the role the child can play in all of this, in addition to the benefits that accrue to the family. They actually, at least it occurred to me, become very much a part of the treatment in a very positive way. And this effect goes beyond the parent directly to the community at large present in the treatment program.

Anyway, thank you, all three of you, for being here.

Senator Coats?

Senator COATS. I just have a brief question. I know time is running out here.

Dr. Wheaton, I was intrigued by your suggestions of family support centers located in neighborhoods and then coordinated services. We have had a director of Catholic social services in Fort Wayne, Indiana, who for years has been advocating this as a means of getting back to a simpler, more efficient, more comprehensive system of delivering coordinated services. They have undertaken a couple of models there that I think show a lot of promise.

I was just wondering, has Connecticut adopted anything like this, or are you aware of any systems that have tried to implement this, and do you know of their success?

Ms. WHEATON. The State of Maryland has several parent education, family support centers. They are called different names in different places. We have 11 parent ed, family support centers in different places in Connecticut. And in addition, there are three family resource centers which are specifically located in schools as a different kind of pilot.

They are basically three models. One is built, the Cambridge model, is built around the health-well clinic. The second is the School of the 21st Century model, which is built around making the school accessible to the entire neighborhood for a variety of purposes.

And the third is the Maryland or Connecticut parent ed, family support center, whose primary purpose is to involve parents in whatever they need to reassure their capacity to parent. And for some, that is as simple as having a washer and dryer because you don't have access to that. For others, it may mean a course in STEP or PET or conflict resolution. But it's whatever it is going to take to support the capacities of those adults to be competent parents. And some of them, as you know, are 15 and 16.

Senator COATS. Have any studies been done to measure the effectiveness of those particular programs versus a comparable neighborhood that doesn't have that service?

Ms. WHEATON. We are just undertaking an independent evaluation, and I suspect in a year we should have pretty reliable data on that.

Senator DODD. That is a fairly new program, too, in Connecticut.

Ms. WHEATON. Yes.

Senator DODD. The State Legislature passed that, was it last year or the year before?

Ms. WHEATON. The family resources are fairly new.

Senator DODD. Yes.

Ms. WHEATON. The family support centers are about three years. But we haven't had an independent evaluation. That is starting now.

Senator COATS. Just one other question, maybe, Dr. Chasnoff or Dr. Mangano will want to answer this.

We have sort of skirted around all afternoon here, what do you do with the pregnant mother who is identified as a heavy drug user, it's the third or fourth or fifth month of pregnancy; she may or may not be open to prenatal services and so forth. You strongly suspect that the amount of drug involvement is going to cause a high probability of damage to the child. What do you do at that point?

I mean if we say, look, involuntary arrest or detention or, as Senator Wilson said, movement to a compassionate rehabilitation service but on a mandatory basis holds out a real possibility that we are going to mitigate considerably the damage to that child and to the mother perhaps. Yet we have been reluctant to impose that kind of thing.

What do you do at that point when you have strongly have probable cause to believe that there is great harm being undertaken to the child?

Dr. CHASNOFF. I think you have to look at this at a community level, not at the individual patient. There are some patients who are not going to come in to prenatal care or treatment. Do you focus your energies and moneys on those women and utilize a lot of your resources by mandating them into treatment when your chances for long-term success are minimal, or do you move on and make programs available to those women who will come in and that you can get services to?

I think one of the problems that we have been dealing with is, you know, asking the question should we be treating pregnant, addicted women as a special group of drug addicts or as a special group of parents? And I think we are going to have to look at this population as a special group of addicted individuals rather than special parents, because when you start, because the woman is pregnant, start imposing certain mandated treatments with her, then you start giving out all sorts of different kinds of messages and many of those women will do the best they can to make sure you don't find out they're pregnant then, because if that woman were using drugs and not pregnant, would you be mandating her into treatment? Most likely not.

Senator COATS. Well, no, but you have a situation here that is not comparable, and that is you've got another life at stake that is potentially astronomical cost to society just in economic terms, but a tragedy in human terms.

Dr. CHASNOFF. But the message you give to the community is to stay away from those people that are putting you "in jail." Now, it may not be jail, it may be a compassionate treatment center, but the message you give out is that there is a punitive approach out there, and for every woman that you mandate into treatment, you are going to lose ten more that will never get any kind of prenatal care when perhaps you had a chance with them.

Senator COATS. Dr. Wheaton, do you want to comment on that?

Ms. WHEATON. I agree with that. I think that I liked your direction or the sense that I have of your direction of the community-oriented, because what I would try to do in terms of your example is to find anybody who knows that woman.

Senator COATS. Which is the beauty of the neighborhood support centers.

Ms. WHEATON. Yes.

Dr. CHASNOFF. Right.

Ms. WHEATON. You have it, because you know, we look at this as the Federal Government and the State Government and just from my perspective, I mean I am a big brother or a big sister, I don't understand the rhythms of the community, and I will tell you, you know, I continue to be impressed that under the most extraordinarily adverse circumstances, if you know the right person to call in a project or a neighborhood, they can find any kid or any mother at any time of day. But most of us most of the time, the professional human service people don't have access to that.

So I would try to find somebody through the informal network to go find this mom and sit down and say, "Look, they're going to give you health service. Go for that. Fight for that."

You know, constitutionally we have no right to treat the mother in terms of the fetus. At least in Connecticut we don't, and I think nationally we don't. But that is a constitutional issue. That presumably can be changed.

I think the question for me is how do we invite that mom who is pregnant and wants to be the best mom in the world, engage her in some kind of support system.

Senator COATS. [presiding.] Thank you.

We are running dangerously late here, and I am going to ask the third panel to come forward.

Senator COATS. Our third panel consists of: Shirley Coletti, Kathleen West, Joe Kroll, and Donna Tice. And I think we will go in that order. I believe the chairman will be right back, and I am late for a meeting in the Capitol, and I have to run. I am sorry I can't listen to you, Shirley.

Ms. COLETTI. I am, too. It's going to be your loss, Senator.

Senator COATS. Well, it is my loss. [Laughter.]

I have losses all over the place this afternoon, with appointments and so forth, and I have another Member of Congress waiting for me in the Capitol.

I think, Shirley, the best thing for you to do is rather than speak to a blank wall here is wait for Senator Dodd.

Ms. COLETTI. That's fine.

Senator COATS. I believe he is just finishing a meeting right outside. [Recess.]

Senator DODD. [presiding.] My apologies to you. I just had a call from the Vice President, and you have to answer the phone. [Laughter.]

So I apologize. That doesn't meant to say you're not as important or more important than the Vice President, but when he does call, I take the call. [Laughter.]

Ms. COLETTI. It just sort of kind of depends on which day it is. [Laughter.]

Senator DODD. Well, it has been, with the votes going back and forth and other things, a little disjointed. But that happens in afternoon hearings as the day gets moving.

I am very grateful to all of you for your willingness to be here and to participate in this hearing.

I am going to begin with Ms. Shirley Coletti, who is the president of Operation PAR, from St. Petersburg, Florida. And you are with Ms. Donna Tice, a program participant in Operation PAR. Ms. Coletti directs the operation of a comprehensive substance abuse prevention and treatment program which serves 33,000 people annually in the Tampa area.

We commend you for that. That is a remarkable effort.

She is joined on the panel by Ms. Kathleen West, the director of program development of the perinatal substance abuse program of Martin Luther King, Jr. General Hospital in Los Angeles. We thank you for being with us.

Ms. West will describe the Eden Center, a program with the purpose of reducing the need for out-of-home placement for high-risk drug-exposed infants and children.

Lastly, Mr. Joe Kroll, who is the executive director of the North American Council on Adoptable Children, from St. Paul, Minnesota. Mr. Kroll represents a large national network of adoptive parents of special-needs children.

We are delighted that you are here with us.

I wanted to ask the question but we will submit it in writing to Mr. Mangano about the statistics on the placement of children and statistically what happens in those situations. But we will submit that question in writing to him, and I am sure you will be interested in the response to that from the study that they have done.

Again, I thank all four of you for being with us this afternoon. Your testimony is extremely valuable to us. I would ask that you try to abbreviate your remarks. Everything you say will be included in the record for sure, but if you can keep your prepared remarks down a little bit, we will get to some questions for you as well.

We will begin with you, Ms. Coletti.

STATEMENTS OF SHIRLEY D. COLETTI, PRESIDENT, OPERATION PAR, ST. PETERSBURG, FL; KATHLEEN M. WEST, MPH, DIRECTOR, PROGRAM DEVELOPMENT, PERINATAL SUBSTANCE ABUSE PROGRAM, MARTIN LUTHER KING, JR. GENERAL HOSPITAL, LOS ANGELES, CA; JOE KROLL, EXECUTIVE DIRECTOR, NORTH AMERICAN COUNCIL OF ADOPTABLE CHILDREN, ST. PAUL, MN; AND DONNA TICE, PROGRAM PARTICIPANT, OPERATION PAR, ST. PETERSBURG, FL

Ms. COLETTI. Thank you, Senator Dodd.

Operation PAR is a comprehensive treatment program. We have been in existence soon to be 20 years, and we for the last 3 years have really begun focusing on the substance-abusing mother and child. And today we have been asked to focus on the challenge that these children will place on the child welfare system.

As you know and have already heard, the child welfare system throughout this country is already overwhelmed. Today, rather than go into a lot of statistics and so forth, which you have already heard and we will be happy to share our statistics with you, I would like to talk a little bit about some things that are working. I think that it's pretty grim when you only hear how devastating the problem is.

What I would like to talk about are some of the things we are doing in Pinellas County, Florida, which is in the Tampa Bay area. But we are providing a comprehensive network of services. Operation PAR is one of the few programs in the Nation that provides such services. As a matter of fact, I don't know of any other program that provides the degree of comprehensiveness that we do. And that has come about by almost 20 years of experience.

Historically we have accepted pregnant women into our residential treatment program. That is an 85-bed therapeutic community. We also have a 30-bed adolescent treatment residential program, but we do not take pregnant women in that program because your 13 to 17 years of age in that program.

All of the PAR programs provide support services to family members, including their children. At PAR, treatment works and it works for everyone. We currently provide one of the, I think, one of the most unique programs in that we provide services to children of substance abusers. It is a program called COSA. We got into this program because we realized that there were so many pregnant substance-abusing women and we wondered what was happening to all of these children.

So with a pilot project grant from the Office of Substance Abuse Prevention, we developed our family, our child development and family guidance center. This program is designed for infants and for children of substance abusers, and it provides and includes a licensed therapeutic developmental daycare center. We work with 31 children, two months of age to five years of age. We work with them in case management for the mothers with parent education and support groups. In addition, we soon will open a day treatment program to work with those mothers who need more intensive services.

The child development and family center works with the significant others as well as with the mothers.

One of the other programs that we are involved in—and you spoke and asked a question earlier of one of the participants about outreach—we developed a program called a maternal intervention team. We call it the I-team. And this program establishes a community-based organized system involving maternal substance abuse. The intervention team functions to identify, to assess, to refer, to follow up and to track cases of maternal addiction. We will provide ongoing education for the mothers and professional training for those who are involved in this intervention team.

We decided and found, and it was with the support of our State's attorney, that many women who are actually in violation of their probation not because they are substance abusing and pregnant but because they are in violation of probation or parole and are pregnant.

We got our State's attorney to join us. We brought in the county health department, child protective services, treatment providers and, obviously, the State's attorney's office, and we sat down around the table and said, "OK, this is a community problem. Let's develop a community approach to the problem." And from that came the maternal intervention team.

We have just begun staffing that team, and it seems to be very, very effective. It works very closely with our child and family development center.

I think one of the most exciting programs that I have been involved with is the program called PAR Village, and this program represents a special partnership between the service provider and the county and community volunteers and the Federal Government.

PAR Village will provide specialized residential treatment to women. The women in the program will be able to keep their children in residence at the PAR Village. What we were able to do is receive 14 right-of-way houses. They were about to be torn down, but they were in excellent condition. And the county provided us with the money. It was about $300,000 to physically move those houses onto our property adjacent to our therapeutic treatment center. We moved the houses.

At the same time, we developed a proposal to the National Institute of Drug Abuse for a research grant, and that helped pay for some of the rehabbing of the houses. We have rehabilitated the houses.

We have been a recent recipient of a NIDA grant which looks at the retention of women in treatment when you have their children in treatment with them.

Traditionally, women do not seek treatment for a variety of reasons, but one major reason is the fact that she cannot bring her children, other children, into treatment with her. So the PAR Village will house up to two children and the mother. She may either be pregnant and/or postpartum.

The program is 18 months in duration, and the actual study will be looking at the moms and babies that are in the PAR Village as opposed to the women that are without their children in our regular therapeutic community. That will be sort of the control group.

Some of the other programs that we are involved in is providing extensive education. I find that one of the major problems—and I am very involved in our State Legislature—one of the major problems is that now that the cocaine baby issue has received a lot of attention, no less than 20 requests for funds came through for the State Legislature. And that amounts to buying rocking chairs for grandmas to rock babies with to special intensive care units for these babies.

I think that one of the responsibilities that we have as providers, and especially those of us with experience, is to help provide protocols for treatment, protocols for working with these children developmentally, protocols for working with the moms, and protocols in helping set up and train employees and train providers to develop some good, comprehensive community-based treatment centers for these women.

I know time is short, and I have a lot that I would like to share with you, and I will provide that in testimony. I did provide one of our brochures. I am most anxious that you have a chance to hear from someone that has been there and can probably tell you a lot.

[The prepared statement of Ms. Coletti follows:]

PREPARED STATEMENT OF SHIRLEY D. COLETTI

TODAY THE TOPIC BEFORE US IS THE IMPACT OF DRUG-EXPOSED INFANTS ON CHILD WELFARE. OPERATION PAR, WHICH STANDS FOR PARENTAL AWARENESS AND RESPONSIBILITY PROVIDES COMPREHENSIVE SUBSTANCE ABUSE TREATMENT AND PREVENTION SERVICES TO OVER 33,000 PEOPLE ANNUALLY IN THE TAMPA BAY AREA. FOR OVER 20 YEARS, PAR HAS PROVIDED SERVICES TO A WIDE RANGE OF PEOPLE IN NEED. FOR THE PAST 4 YEARS, PAR HAS FOCUSED ON THE EMERGING ISSUE OF CRACK COCAINE AND CHILDREN. BY ALL REPORTS, THE EFFECTS OF THE CRACK COCAINE EPIDEMIC ARE OVERWHELMING. THE ONE STATISTIC THAT CRYSTALLIZES THE URGENCY OF THE CRISIS IS CURRENT ESTIMATES FROM THE RECENTLY COMPLETED STUDY IN PINELLAS COUNTY THAT CITES 1 OUT OF EVERY 7 WOMEN (14.8%) ON THEIR FIRST PRENATAL VISIT HAS A URINE TOXICOLOGY POSITIVE FOR DRUGS OF ABUSE. (A SUMMARY OF THE FINDINGS HAS BEEN PROVIDED)

REPORTS FROM AROUND THE COUNTRY MIRROR THE STUDY FINDINGS IN PINELLAS COUNTY. THE FLORIDA DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES COMPILED DATA THAT CITED CONFIRMED COCAINE EXPOSED BIRTHS FROM JULY 1, 1987 TO SEPTEMBER 30, 1987 AT 475 CASES. BY 1989 REPORTED CASES JUMPED TO OVER 900 CASES REPORTED IN A SINGLE QUARTER OF 1989 (01-01-89 TO 03-31-89). CLEARLY WE ARE FACED WITH A CRISIS.

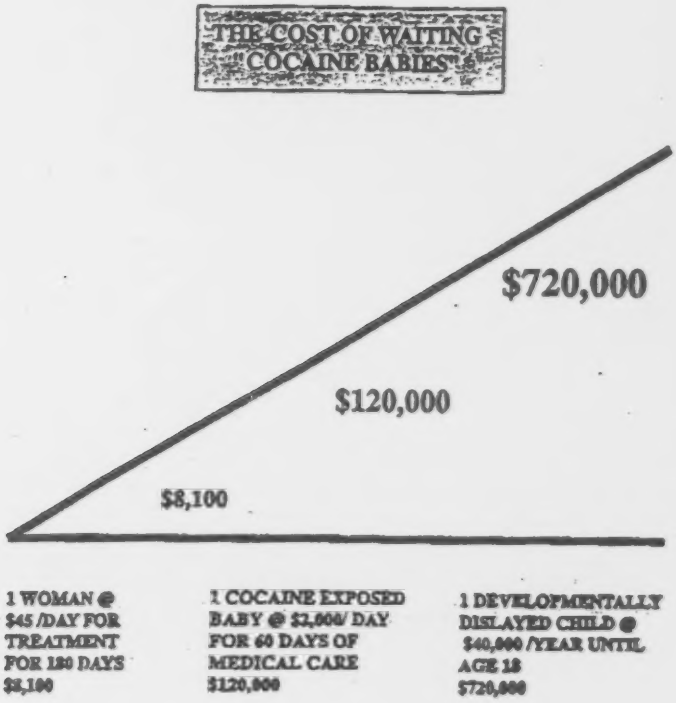
COCAINE CHILDREN ARE A PROBLEM IN OUR STATE

- BY THE END OF 1989, OFFICIALS ESTIMATED THAT OVER 10,000 COCAINE EXPOSED BABIES WILL BE BORN IN FLORIDA
- DRUG-AFFECTED BABIES OFTEN REQUIRE EXPENSIVE MEDICAL CARE
- MEDICAL COSTS HAVE EXCEEDED $400.00 PER DAY, THESE "INNOCENT ADDICTS" LENGTH OF STAY IN HOSPITALS ARE SIGNIFICANTLY LONGER THAN UNAFFECTED BABIES
- PREVENTION AND INTERVENTION SERVICES ARE NECESSARY TO ADDRESS THE TREATMENT NEEDS OF THE MOTHER AND PROVIDE

MUCH NEEDED DEVELOPMENTAL SERVICES TO THE CHILDREN

- MANY COMMUNITY-BASED TREATMENT SERVICES ARE WILLING TO PROVIDE COST-EFFECTIVE QUALITY SERVICES TO SUBSTANCE ABUSING WOMEN AND THEIR CHILDREN IF RESOURCES CAN BE MADE AVAILABLE

WHAT ARE THE COSTS TO SOCIETY:


THE COST OF WAITING
"COCAINE BABIES"
$720,000
$120,000
$8,100
1 WOMAN @ $45 /DAY FOR TREATMENT FOR 180 DAYS $8,100
1 COCAINE EXPOSED BABY @ $2,000/ DAY FOR 60 DAYS OF MEDICAL CARE $120,000
1 DEVELOPMENTALLY DISLAYED CHILD @ $40,000 /YEAR UNTIL AGE 18 $720,000

COCAINE, COCAINE ADDICTION AND COCAINE CHILDREN ARE A COMPONENT OF A VERY COMPLEX PROBLEM. YOU HAVE HEARD FROM MANY AUTHORITIES ON THE RANGE OF DEVELOPMENTAL PHYSICAL AND PSYCHOLOGICAL HURDLES THESE CHILDREN WILL FACE.

TODAY WE HAVE BEEN ASKED TO FOCUS ON THE CHALLENGE THESE CHILDREN WILL PLACE ON THE CHILD WELFARE SYSTEM. CHILD WELFARE SYSTEMS THROUGHOUT THIS COUNTRY ARE ALREADY OVERWHELMED. SYSTEMS AND RESOURCES ARE JUST SIMPLY NOT ABLE TO MEET THE CURRENT DEMAND FOR SERVICES, LET ALONE THE INCREASED DEMANDS THAT THIS POPULATION PRESENTS. THE SOLUTION TO MEETING THE NEEDS OF THE DRUG-EXPOSED CHILD RELIES ON OUR COLLECTIVE ABILITY TO PROVIDE COMPREHENSIVE COMMUNITY-BASED CARE. THE ANSWER WILL NOT BE FOUND IN ONE "MAGIC" PROGRAM, BUT IN A COMMUNITY THAT CAN LOOK AT THE ISSUE FROM ALL SIDES AND ESTABLISH A COMPREHENSIVE NETWORK OF SERVICES. OPERATION PAR AND PINELLAS COUNTY IS ONE SUCH COMMUNITY. IN THE PAST 20 YEARS PAR HAS PROVIDED COMPREHENSIVE DRUG ABUSE SERVICES TO PINELLAC COUNTY, WOMEN HAVE ALWAYS HAD ACCESS TO TREATMENT. PAR HAS HISTORICALLY ACCEPTED PREGNANT WOMEN INTO RESIDENTIAL CARE. ALL PAR PROGRAMS PROVIDE SUPPORT SERVICES TO FAMILY MEMBERS INCLUDING CHILDREN. AT PAR, TREATMENT WORKS... AND IT WORKS FOR EVERYONE.

OPERATION PAR CURRENTLY PROVIDES ONE OF THE MOST COMPREHENSIVE SERVICE DELIVERY SYSTEMS FOR ADDICTED WOMEN AND THEIR CHILDREN IN THE COUNTRY. OUTSIDE OF PAR'S ONGOING OUTPATIENT AND RESIDENTIAL SERVICES ARE SPECIALIZED SERVICES. THE PROGRAM/SERVICES INCLUDE:

1. <u>MATERNAL SUBSTANCE ABUSE INTERVENTION TEAM</u>

THIS PROGRAM ESTABLISHES A COMMUNITY-BASED ORGANIZED SYSTEM OF INTERVENTION FOR CASES INVOLVING MATERNAL SUBSTANCE ABUSE. THE INTERVENTION TEAM FUNCTION IS TO IDENTIFY, ASSESS, REFER, FOLLOW-UP AND TRACK CASES OF MATERNAL ADDICTION. IN ADDITION, THE PROGRAM WILL PROVIDE ON-GOING EDUCATION AND PROFESSIONAL TRAINING. THE INTERVENTION TEAM S OUR EARLY WARNING SYSTEM. THROUGH COOPERATION WITH PUBLIC HEALTH SERVICE PROVIDERS AND THE JUSTICE SYSTEM WE ARE AWARE OF THE EXTENT OF THE PROBLEM AND CONTINUALLY DEVELOPING NEW APPROACHES TO MEET THE NEEDS.

2. <u>CHILD DEVELOPMENT AND FAMILY GUIDANCE CENTER</u>

THIS PROGRAM IS ESPECIALLY DESIGNED FOR INFANTS AND CHILDREN OF SUBSTANCE ABUSERS. SERVICES PROVIDED INCLUDE A LICENSED THERAPEUTIC DEVELOPMENTAL DAY CARE CENTER FOR OVER 30 CHILDREN, 2 MONTHS TO 5 YEARS OF AGE; CASE MANAGEMENT FOR THE MOTHERS; PARENT EDUCATION AND SUPPORT GROUPS. IN ADDITION, PAR WILL SOON OPEN A DAY TREATMENT COMPONENT FOR THE MOTHERS. THE CHILD DEVELOPMENT AND FAMILY GUIDANCE CENTER WORKS. STAFF REPORT SIGNIFICANT

DEVELOPMENTAL AND SOCIALIZATION OF CHILDREN IN THE PROGRAM. ONE SUCH CHILD IS "PRECIOUS". PRECIOUS WAS UNDER 21 LBS. TODAY PRECIOUS IS 9 MONTHS OLD, ALTHOUGH SHE IS DEVELOPMENTALLY DELAYED SHE HAS MADE SIGNIFICANT IMPROVEMENTS.

3. PAR VILLAGE:

THIS PROGRAM REPRESENTS A SPECIAL PARTNERSHIP BETWEEN THE SERVICE PROVIDER, THE COUNTY, COMMUNITY VOLUNTEERS AND THE FEDERAL GOVERNMENT. PAR VILLAGE WILL PROVIDE SPECIALIZED RESIDENTIAL DRUG TREATMENT TO WOMEN. THE WOMEN IN THE PROGRAM WILL BE ABLE TO KEEP THEIR CHILDREN IN RESIDENCE AT PAR VILLAGE. THE MOTHER RECEIVES QUALITY LONG TERM RESIDENTIAL TREATMENT, CHILDREN RECEIVE SPECIALIZED DEVELOPMENTAL SERVICES AND COUNSELING. PAR VILLAGE IS AN ENHANCEMENT OF PAR'S SUCCESSFUL THERAPEUTIC COMMUNITY. PAR VILLAGE IS A LONG-TERM (18-24 MONTHS) PROGRAM. THIS SPECIAL SERVICE PROVIDES A "HOME" LIVING SITUATION WITH THE SUPPORT OF A THERAPEUTIC COMMUNITY.

4. EDUCATION/NETWORKING/
RESEARCH:

OPERATION PAR ON AN ON-GOING BASIS, PROVIDES COMMUNITY EDUCATION THROUGH SPECIALIZED PRESENTATIONS, OUTREACH AND MEDIA CAMPAIGNS. IN ADDITION, PAR COORDINATES AN ANNUAL SOUTHEAST REGIONAL CONFERENCE THAT PROVIDES PROFESSIONAL EDUCATION TO OVER 600 PEOPLE ANNUALLY. PAR ALSO COORDINATES THE FLORIDA PERINATAL ADDICTION NETWORK AS WELL AS THE SOUTHEAST REGIONAL CHAPTER OF THE NATIONAL ASSOCIATION FOR PERINATAL ADDICTION RESEARCH AND EDUCATION (NAPARE). IN ADDITION, PAR IS ACTIVELY INVOLVED IN MANY RESEARCH PROGRAMS FOCUSING ON THE ASPECTS RELATIVE TO COCAINE USE, PREGNANCY AND CHILDREN.

ALTHOUGH THE ANNOUNCED FOCUS OF TODAYS HEARING WAS THE IMPACT ON THE DRUG EXPOSED CHILD ON THE CHILD WELFARE SYSTEM, IT IS DIFFICULT TO LIMIT OUR FOCUS. THE PROBLEM IS DRUG ABUSE. IF WE LIMIT OUR DISCUSSIONS TO THE DEVELOPMENTAL NEEDS OF THE CHILD WITHOUT CONSIDERING THE NEEDS OF THE MOTHER WE CANNOT HOPE TO FIND A SOLUTION.

THE SOLUTION TO THE IMPACT OF COCAINE EXPOSED CHILDREN LIES SQUARELY IN PROVIDING COMMUNITY BASED SERVICES. THE DAMAGE COCAINE HAS ON COMMUNITIES, ON SERVICE SYSTEMS, FAMILIES AND CHILDREN IS DEVASTATING. AS WE BEGIN TO LOOK FOR RELIEF WE MUST IDENTIFY LONG AND SHORT TERM GOALS. THERE ARE IMMEDIATE NEEDS:

* EDUCATION AND TRAINING FOR PROFESSIONALS
* OUTREACH TO MOTHERS
* SPECIALIZED PROGRAM SERVICES FOR THE AFFECTED CHILD LIKE PAR'S DEVELOPMENTAL DAY CARE CENTER
* ACCESS TO PRENATAL HEALTH CARE

* SUBSTANCE ABUSE TREATMENT FOR THE MOTHER

LONG-TERM NEEDS:

* CHILD CARE PROVIDERS NEED SPECIALIZED TRAINING IN DEALING WITH DRUG EXPOSED CHILDREN.

* THE EDUCATION SYSTEM MUST BEGIN TO ADDRESS THE SPECIALIZED CHANGES THAT THE EMERGING POPULATION OF DRUG EXPOSED INFANTS PRESENTS.

* CHILD WELFARE, SOCIAL SERVICE, SCHOOLS AND COMMUNITY-BASED TREATMENT PROGRAMS NEED TO WORK TOGETHER.

NO ONE DISCIPLINE HOLDS THE ANSWER TO THE PROBLEM BEFORE US. NO ONE PROGRAM HOLDS THE KEY. HOWEVER, "MODEL" PROGRAMS DO EXIST. PROTOCOLS FOR TREATMENT HAVE BEEN ESTABLISHED. IN OUR COMMUNITY, AGENCIES AND SERVICE PROVIDERS ARE WORKING TOGETHER. I WOULD URGE THE COMMITTEE TO ACT QUICKLY. TODAY COUNTLESS NUMBERS OF WOMEN IN AMERICA ARE ADDICTED AND PREGNANT. WE NEED TO INTERVENE QUICKLY FOR THE SAKE OF THE MOTHER AND THE CHILD.

TRADITIONALLY WHEN AMERICA FACES A DIFFICULT ISSUE WE RESEARCH AND STUDY. THE PROBLEMS RELATED TO DRUG ABUSE, OF WHICH THE ISSUE OF EXPOSED CHILDREN IS JUST ONE ASPECT, HAS REACHED EPIDEMIC PROPORTIONS. AS WE APPROACH THE ISSUE WE ALSO MUST LOOK AT A VERY COMPLEX PROBLEM COMPREHENSIVELY. IF YOU FRACTIONALIZE THE ISSUES AND DEVELOP RESPONSES ACCORDINGLY, WE ARE IN DANGER OF LOSING GROUND. MODEL PROGRAMS EXIST AND LIKE PAR ARE READY TO HELP.

THE UNITED STATES RECOGNIZES THE DEVASTATING AFFECT OF ENVIRONMENTAL HAZARDS AND ACCIDENTS ON OUR QUALITY OF LIFE. THE "SUPERFUND" WAS ESTABLISHED TO QUICKLY RESPOND TO CRITICAL SITUATIONS. TO TRULY IMPACT THE DRUG PROBLEM WE MUST LOOK AT THE PROBLEM AS CRITICAL, AS A THREAT TO OUR "QUALITY OF LIFE". AS A DRAIN ON OUR MOST PRECIOUS NATURAL RESOURCE - OUR CHILDREN WE NEED TO ENLIST THE SUPPORT OF PROGRAMS LIKE PAR TO REPLICATE PROGRESS, TO HELP COMMUNITIES LEARN FROM OUR SUCCESS.

THE DECLARATION OF THE UNITED NATIONS STATES THAT "MANKIND OWES TO THE CHILD THE BEST IT HAS TO GIVE".

AS A COUNTRY WE MUST GIVE OUR CHILDREN NOT ONLY A SOUND GOVERNMENT, A CLEAN ENVIRONMENT, BUT A FAMILY, A HOME AND A FUTURE FREE OF DRUGS.

WHEN WE OPENED PAR'S VERY FIRST PROGRAM, FOR SUBSTANCE EXPOSED INFANTS, THE ANNOUNCEMENT OFFERED THE FOLLOWING QUOTATION:

"THERE IS ALWAYS ONE MOMENT IN CHILDHOOD WHEN THE DOOR OPENS AND LETS THE FUTURE IN".

THANK YOU TO THE COMMITTEE FOR OPENING THE DOOR TO A DRUG FREE FUTURE FOR OUR CHILDREN AND OUR COMMUNITIES.

THANK YOU.

OPERATION PAR
Parental Awareness & Responsibility
FACT SHEET

Operation PAR is a comprehensive non-profit substance abuse prevention and treatment organization. PAR was founded in 1969 by Shirley D. Coletti and community leaders. Mrs. Coletti has served Operation PAR as its President since its founding. Annually, PAR provides service to over 28,000 people in the Tampa Bay area. PAR services include an 84 bed adult long-term residential treatment center, a 30 bed adolescent residential program, medical detoxification services, outpatient counseling and prevention programs for the entire community.

In addition, PAR has received funding from the Office of Substance Abuse Prevention to establish a model program for children of substance abusers. The Child Development and Family Guidance Center provides specialized developmental day care for infants exposed to illegal drugs and also provides outreach and case management for the mothers. PAR is currently in the final stages of expanding its residential treatment capacity to include care for women and their dependent children.
PAR has provided comprehensive drug abuse services for nearly two decades.

In 1986, PAR was recognized as "the most outstanding program in the United States" by the Alcohol and Drug Probelems Association of North America.

Funding for PAR is provided by the Juvenile Welfare Board of Pinellas County, the United Way, HRS, client fees, insurance and donations. PAR accepts all clients regardless of ability to pay.

LOCATION:
OPERATION PAR
MCCORMICK CENTRE SUITE 1000
10901-C ROOSEVELT BLVD.
ST. PETERSBURG, FL 33716
(813) 570-5080

FOR MORE INFORMATION:
MARY ANN ANDREWS
DIRECTOR OF COMMUNICATIONS
(813) 570-5080

EXTENT OF PROBLEM

In 1988, **5,200** babies were born in Florida were "cocaine exposed".

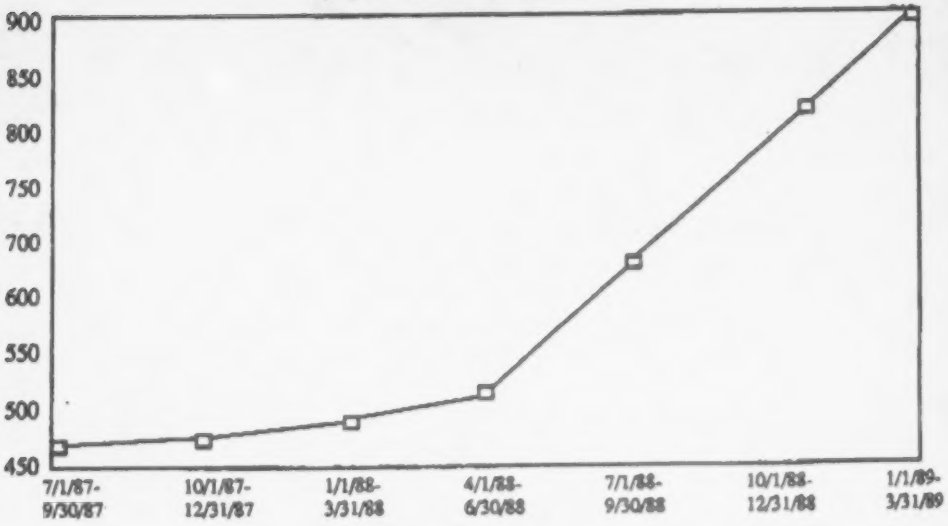
By the end of 1989, it has been estimated that over **10,000** babies will be born in Florida "cocaine exposed".

A recently released study conducted in Pinellas County by Operation PAR and Northwestern University suggests that the problem may be even greater.

The study indicates that **1 out of every 7** infants may have been exposed to illegal drug use during the mothers pregnancy.

28-384 0 - 90 - 6

Cocaine Baby Births in Florida
All Districts
By Quarters 7/1/87 - 3/31/89



Source: Florida Department of Health and Rehabilitative Services

PRENATAL DRUG USE IN PINELLAS COUNTY

WHAT: A recent study was conducted by the National Association for Perinatal Addiction Research and Education (NAPARE), in conjunction with Operation PAR, a St. Petersburg, Florida drug treatment program.

WHY: The purpose of the study was to look at the prevalence of drug use during pregnancy in a sample of pregnant women in Pinellas County, Florida, as well as aspects of the reporting of such cases. Florida has a policy that requires hospitals to notify local health departments when an infant is born with drugs in its system or the mother is an addict.

WHO: 715 pregnant women from both public and private health care sectors were involved.

HOW: From January 1, 1989 until June 30, 1989, a urine sample for toxicology was collected from every woman at her first prenatal visit as she entered care at any of the 5 public health clinics or in 12 of 20 private obstetric offices in the county. Urine samples were tested for cocaine, marijuana, opiates and alcohol.

FINDINGS:

- 14.8% of all women tested positive for cocaine, marijuana, opiates and/or alcohol.
- There were no significant differences in the rates of public or private patients. 13.1% of women receiving private care, and 16.3% of women receiving care in a public clinic, tested positive for alcohol and other drugs.
- Though white women (15.4%) had a slightly higher rate than black women (14.1%), differences in the rates of those testing positive for alcohol and other drugswere not significant.
- Marijuana was the drug used most often in the overall group.
- Cocaine was used by 7.5% of black women and 1.8% of white women.
- Because alcohol is metabolized and excreted eight hours after consumption, it is likely that the use of alcohol was more frequent than the urine tests could determine.
- Although white women were 1.09 times as likely as black women to have used drugs or alcohol, black women were 9.58 times as likely to be reported to county health authorities for substance abuse during pregnancy.

Incidence of Drug Use in Pregnancy PInellas County, Florida Oct. 1989

Ira J. Chasnoff, M.D.
Principal Investigator
Northwestern University Medical School

Purpose: Estimate the incidence of substance abuse by pregnant women in Pinellas County.

Method: During January - June, 1989 urine samples were collected from patients during their first prenatal visit to five Pinellas County Public Health Units and 12 of the County's 17 private obstetricians.

In total, 715 patients particicpated:
- Public Health Patients (n=380)
- Private Care Patients (n=335)

Urine samples were analyzed "in the blind" by EMIT testing for :

alcohol	cocaine
marijuana	opiates

In addition, an analysis was conducted of Public Health records of women reported for drug/alcohol abuse during pregnancy for the same time period.

Study Funded By
The Pinellas County Juvenile Welfare Board

Explanation for Findings

Black women were 10 times more likely to be reported for drug use during pregnancy

1. The symptoms of Black infants may be more obvious and intense due to mother's differential use of cocaine.

2. Physicians who specialize in care of minorities or lower economic groups may be more aware and better skilled at diagnosing drug abuse.

3. Private obstetricians may be reluctant to identify cases due to fear of patient reactions, loss time, or patient referrals.

4. There may be a fear on part of hospitals that they will be identified as a hospital for "drug babies".

5. There may be an existent stereotype of the drug user as a minority, urban, lower socio-economic member thus leading to over or under diagnosis of the problem.

ADDICTED INFANTS AND THEIR MOTHERS

The National Select Committee on Children, Youth and Families led by Congressman George Miller talked with hospitals in large metropolitan areas about damage caused by substance abuse during pregnancy. The results of their survey were released at hearings on April 27, 1989.

FINDINGS:

- **Fifteen of the 18 hospitals surveyed reported three to four times as many drug-exposed births since 1985.**
- **Drug-exposed babies are more likely to be born prematurely and have low birthweight, dramatically raising their risk of infant mortality and childhood disability.**
- **Women who seek help during pregnancy cannot get it. Two-thirds of the hospitals reported that they had no place to refer substance-abusing pregnant women for treatment.**
- **Hospitals in Los Angeles and Washington, D.C. reported the re-emergence of maternal death during labor and delivery directly attributable to drug abuse during pregnancy.**
- **Eight hospitals reported growing numbers of "boarder babies" who remain in hospitals because their parents abandon or cannot care for them.**

Rep. George Miller of California writes:

"While the number of drug-exposed babies remains relatively small, they are among the most expensive babies we care for. And, these children have the ability to swamp every system involved with their care - hospitals, child protective services, foster care, and schools.

Hospitals we surveyed cautioned that their estimates vastly undercount the number of women and children affected. They indicated, as well, that these newborns stay in the hospital up to 13 days longer than healthy infants, at a cost which can reach nearly $1,800 a day.

These problems are no longer confined to inner cities. In my suburban district in California, 40 babies a month are born drug-exposed, and these children now represent 60-75% of foster care caseloads in the country."

BENEFITS OF ALCOHOL AND DRUG TREATMENT FOR WOMEN

- ❒ alternative to incarceration that is less costly
- ❒ reduction of criminal activity while in treatment
- ❒ medical care for clients to prevent the spread of communicable diseases (STD'S AND AIDS)
- ❒ prenatal care for expectant mothers who are involved with alcohol and drugs
- ❒ upgrading of education level (ged)
- ❒ reduction in the number of alcohol and drug exposed infants
- ❒ reduction in school dropouts as a result of alcohol and drug abuse
- ❒ help for families with a substance abuse problem and prevention of third generation substance abusers

Senator DODD. Let me compliment you on the tremendous job you have done, particularly when you can get the person into a drug treatment program and can provide for several of the children to be there as well. I mean that is really beyond what I have heard that any program does. So I compliment you.

Ms. COLETTI. Thank you.

Senator DODD. We thank you for coming here as well, Donna Tice, and being with us this afternoon. We will be delighted to hear what you have to say.

Ms. TICE. GOOD AFTERNOON, SENATOR.

Senator DODD. You have to speak right into that microphone.

Ms. TICE. All right.

Senator DODD. I apologize. The acoustics aren't the best.

Ms. TICE. Well, 5 years ago I was a drug-addicted mother-to-be. And even though I wanted to quit, my need for the cocaine was greater than my maternal instinct, and I continued to abuse myself and my unborn baby. And as the guilt of what I was doing to myself became overwhelming, I sought drug treatment, and I was unable to find a treatment center that would accept me pregnant. So I had to lie to get into one. I also avoided prenatal care for fear of being pressured into an abortion or adoption of my child.

Then again, I didn't have the time to sit in a clinic all day just to have the doctor and a nurse measure my stomach, test my urine, and tell me to come back next week. I would rather have been out getting high.

OK. Now back to treatment. It didn't work for me the first two times because I did it to please someone else. It was either to keep my children or it was to please other members of my family. Not until I was ready to change my own disruptive behaviors did I absorb any of what was being taught in treatment.

And honestly, I believe that if there had not been a program such as Operation PAR's COSA, which is Children of Substance Abusers, I would either be trying to find a program similar to that or I would be using drugs again.

OK. COSA provided the support system that I needed as a recovering female addict. And I needed motivation and encouragement to get back into the mainstream of life. Also, my daughter needed the love and care and stability that I didn't or couldn't provide as an addict.

OK. Through the loving and caring and teaching staff at COSA, my daughter has changed from a withdrawn, angry little girl to a vivacious, energetic, inquisitive five-year-old. And today I see a real need for treatment programs that cater to the specific needs of pregnant women and the unborn children. Also, the staff at these treatment centers must be sensitive people that can help with the ultimate goal of helping the female addict regain self-respect and control of their life. And for the children who are affected by their mothers' behavior, there must be some sort of intervention and evaluation before they enter public school so that that child can make a positive impression and have an equal chance to have a successful school career.

Thank you.

Senator DODD. Thank you. That was a very fine statement. We thank you for being here today to make it. I should also say I have

a deep respect for your being willing to come in a public forum and talk about this as well. It takes a lot of courage to do that.

Ms. TICE. Thank you.

Senator DODD. With all due respect to the other panelists and others who have been with us, all the people who work very hard in these areas, it is always so tremendously helpful to have someone like yourself who has actually been through this and can speak with firsthand knowledge about it. And I know I am speaking not only for myself and my colleagues here, but for your copanelists as well. It is tremendously instructive to have someone speak very plainly about what it's like. So I thank you for being here today.

Ms. TICE. Thank you.

Senator DODD. Ms. West, we thank you for being here.

Ms. WEST. Thank you, Mr. Chairman, for convening this hearing. In the interest of time I will go immediately to a brief description of our program's philosophy and approach, as your committee requested.

Up front I will tell you that my testimony may be slightly atypical, especially since our programs are affiliated with the pediatric department because our programs really focus to a very large extent on the mothers, and I think that the topic today is really children. However, the focus on mothers is based on their unfortunately long history of dealing with the crack cocaine problem in newborns at Martin Luther King Hospital in Los Angeles, which really came in strongly in 1984–85. And before that, I may say in deference to Senator Adams' earlier comments today, PCP was our problem and definitely our next problem on the horizon is methamphetamines, which is already the leading drug of choice in San Diego County.

What we learned by making some mistakes in the past is that removing drug-exposed babies from their mothers at birth is no panacea.

We therefore are adamantly suggesting that the answer for the mothers, who very often do go on to have yet another drug-exposed baby, or the infants who very often are bounced from foster home to foster home to group homes and who learn not to attach, not to explore, not to bond, etc, is that they do need to be placed together.

Our programs, the oldest of which was just started a little over 2 years ago, the Eden Center, have decided therefore to put all of our eggs in the basket of the mother, as it were.

This approach, that of believing that in about 70 percent of our identified drug-exposed families, we believe that believing in and working toward family maintenance, it's not only in keeping with the Federal law, Federal law 96–272 and California's implementation of that, it appears to both work and be cost effective.

Even with that philosophy in place, however, we initially made some mistakes in our program design, because we didn't take into account the fact that moms coming to our programs in various states of readiness, as Donna Tice just suggested, for drug recovery and with varying parenting skills and their infants enter with various degrees of affectedness through the prenatal drug exposure.

Not all, in fact, in our experience at Martin Luther King to date, where we deliver about 50 to 60 drug-exposed infants a month, not most of our babies are very seriously affected. We have therefore

learned that we need interrelated programs that operate distinctly but in a concentric circle sort of fashion with varying levels of intensity and time duration.

The key to success in these programs is initial assessment, therefore, to ensure that mothers and their drug-exposed baby are directed into the right program at the right time. We must not set these families up to fail.

A theme throughout all of our programs—and you have a summary of that in front of you; we now have four perinatal substance abuse programs—include three therapeutic components:

One, working with the mother as a woman. She usually has many problems that preceded her becoming a mother, and we very often don't focus on those issues;

Two, we work with the infants and children as individuals and with unique developmental needs so that we can also observe them and learn from them still what we don't know. As you have heard so much today, there is very little data on long-term follow-up with these children;

And three, we work very intensely on mother-infant interactions to help the mothers reinterpret their children's behaviors and become more clear about what some of their children's interactions with them really mean.

All of our programs also have both a center and home-based component. The home-based component we think is very important in that it brings functioning people into homes in many housing projects, etc, where there may not be such people, and we therefore lend stability.

It also is a reality test for our staff to make sure that the programs we are operating in the center-based component actually can be implemented in the home and then to follow up and help the mothers implement in the home what they are learning at the center.

The reason for our emphasis on the center-based program, even though all of our programs are outpatient, is that we think it's very important to stop the social isolation that so many of these families have from, if you will, functioning people in more mainstream society.

They also provide peer support groups and shared insights from others, other women in shared circumstances, which is invaluable. And they also introduce structure and routine into lives of both mothers and kids.

They also offer a view of an alternate life style and all of our programs are community-based within about a mile of the hospital, and we use the hospital therefore as a clearinghouse and resource for many medical services that these families need.

It also provides a familiar and stable place for these families when they come into times of crisis that even the older children can turn to, and we very often find that happening.

Throughout all of our programs we also never lose sight of the fact that our mothers are in various stages of addiction and are recovering, even though we are coming from a maternal and child health perspective, from a pediatric department.

What we have learned, therefore, from this experience is that we must expect relapses in this population. In our experience with

crack use especially, we expect about four relapses in the first year of recovery, and we don't let our mothers leave our therapeutic milieu if at all possible. We do whatever we must do in order to keep them in this flexible environment, making our programs as flexible and as appropriate to their needs as possible. That means we have a 24-hour "warm line." That means we are available from 11 p.m. to 7 a.m., if that's what's required. And it means keeping them in the programs with the only possible reason is total nonparticipation on their part for a long time to cause termination from our program.

We also take the prenatal drug exposure into account for infants and children and therefore make sure that all of our children are followed up in high-risk intensive follow-up clinics at tertiary centers where physicians have a high index of suspicion and a great deal of familiarity with drug-exposed infants.

One of our concerns about children in foster placement often is that they may be seen by physicians in the community who, with all due respect to folks out there, may not have read a journal in many, many years nor are they aware of how to diagnose some of the subtle problems that drug-exposed infants have. Therefore, they need to be seen in tertiary medical centers with experience in dealing with these children.

We are also particularly sensitive to their special developmental needs and have child development specialists on the staff, drawing on these children's strengths and helping to modify their environment in our center and in their homes so that they experience as much success and well-being as possible.

What we can't always do but we know needs to happen is that we desperately need to arrange the marriage of disparate disciplines. Right now as a maternal and child health specialist and epidemiologist, I find it difficult sometimes to think of myself working with the LAPD and other kinds of agencies very closely, but we not must be talking to each other but working together. That is something that professionals in the field need to do and need to be encouraged to do to build coalitions and really work jointly on this interdisciplinary problem.

What you as lawmakers and policymakers can help us do is to ensure that our social commitment to maintaining families to Public Law 96–272 and making it work is in reality not only on paper. That means that funding must be available for cost-effective programs that are directed toward mothers and babies together.

These are not as easy to organize as centralized programs, but we believe that they have much more staying power. Unless we are going to raze communities like Watts and Central Harlem and start from scratch, our mothers are going to have to learn how to live on the streets where crack is available for $2.50 to $10 a rock. And this means that their recovery period is going to be more long-term and they're going to have to learn coping skills that will allow them to live alongside this drug-free.

We expect our mothers and our children to be in our programs for up to 18 months, although our programs have varying lengths of time. And we recognize that while their problems in drug use didn't develop in 30 days and therefore we don't expect to be cured in 30 days.

In LA County, the average annual cost of caring for a child age zero to three in what we are calling group homes, which may have up to 45 beds, is $44,298 per child per year, according to the State Department of Social Services data. All of our current programs, which include project support, the Eden Center, the Children's Arc, the Hero program, maternal and psychological profiles project and prenatal care outreach have an annual budget of just over $300,000, for which amount we served over 275 families with over 400 infants and children under the age of 4, 72 of whom received intense services last year.

While we have heard a lot of bleak testimony today, I would like to tell you that I think that many of these families, and we estimate about 60 to 70 percent, can be maintained and worked with together. We think one of the very important keys to success in that is assessing them correctly and not putting them in programs where we set them up to fail, but matching them with the right services that they need.

Thank you.

Senator DODD. Thank you very much.

[The prepared statement of Ms. West follows:]

THE SHIELDS FOR FAMILIES PROJECTS
2115 N. WILMINGTON AVENUE
COMPTON, CALIFORNIA 90222
(213) 605-0650 or 605-0651

2/1/90

PREPARED STATEMENT OF KATHLEEN M. WEST

PROGRAMS' PHILOSOPHY & APPROACH

1) Premise of all programs is that Family Maintenance is feasible.
Key to success is initial assessment to ensure that mothers and children are directed into the right program at the right time. (see attached program description.) DONT set clients up to fail.

2) Must have comprehensive family-focused interventions.
All SHIELDS projects have three therapeutic components:
i) mother as woman, not only her role as mother;
ii) infant/child as unique individual with special developmental needs;
iii) mother/infant interactions.

3) Must have both Home- and Center-based components in all programs;
This high risk population needs home-based component to (a) lend stability and outside influence in that setting; and (b) assist in implementation of Center-based learning/activities in the home setting.
Also needs Center-based component to (a) stop social isolation from functioning persons; (b) provide peer support group and interaction with other recovering mothers in similar situations; (c) introduce structure and routine into lives of mother and child(ren) and keep child visible in the community; (d) offer view of alternate lifestyles/hope; and (e) provide familiar place to turn in trouble--for both mother and other family members (including older children).

4) Must adress more than drug problem, but MUST take drug addiction into account in ALL other program activities. Expect relapses (about four in the first year) and keep program flexible and available to clients throughout these relapse experiences.

5) Must have marriage of not only professionals from both maternal and child health and drug treatment fields, but wedding of heretofore categorical funding streams.

OUTLOOK FOR FAMILY PRESERVATION

Prospect for family preservation is good for about 70% of families IF:

1) program accurately identifies the "workable" 70% and directs them into the right program;
2) program is realistic about level of maternal functioning at program "outcome";
3) program is realistic and can "enforce" long-term commitment to/from client (18 mo.);
4) program takes intergenerational issues into account and works with all family members;
5) social commitment to BUILD and preserve families is strong and continuous:
   - funding streams must be available;
   - initial trend towards "group homes"/congregate care/ orphanages is stemmed.

2/1/90

THE SHIELDS FOR FAMILIES PROJECTS
2115 N. WILMINGTON AVENUE
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The SHIELDS for Families Projects are currently comprised of three therapeutic non-residential programs for drug and alcohol abusing women, their drug-exposed newborns, and other high risk children. SHIELDS' goals are to increase the number of substance-abusing women seeking prenatal care, to help maintain them in medical and drug treatment, and to assist them in maintaining their biological families through re-parenting, and parent skill-building. To increase the number of infants cared for within their biological families (vs. foster placement), the programs provide family support services in both Center-based and home-based settings. Because potential clients present in various states of "readiness" for program participation, SHIELDS affords them several avenues of access to therapeutic settings with differing levels of intensity of program involvement. The SHIELDS Projects include:

Project Support is the least intensive project within the SHIELDS for Families Project, with the largest client population, offering regular group counselling sessions on a long-term basis, home visits, and therapeutic child care for drug-using and recovering women and their drug-exposed infants and young children. Project Support accepted its first clients in January 1988, is based at the King/Drew Medical Center and receives all its referrals directly from the Martin Luther King Hospital nursery. Women involved in Project Support are generally contacted following delivery of a drug-exposed infant and prior to the infant's discharge from the hospital. Participants of both The EDEN Center and The Children's ARK also attend Project Support group counselling sessions. Project Support is funded at a rate of $120,000 per year by the Los Angeles County Drug Abuse Program Office and has served more than 400 women and 800 children since it was established in January 1988.

The EDEN Infant, Child and Family Development Center is a program of early developmental assistance for drug-exposed newborns and their families with special needs. The EDEN Center is the longest term and most intensive out-patient project within The SHIELDS Projects, offering a comprehensive range of services for the maternal and child clients. Participants in EDEN are generally those most willing and motivated to make a long-term commitment (up to three years) to recovery and family-building within the structure of the therapeutic, cooperative Center and home-based component of EDEN. A Cocaine Anonymous Support Group is a special feature of The EDEN Center that is open to all SHIELDS Programs participants. The EDEN Center accepted its first participants in December 1987 and is housed at St. Martin's Episcopal Church, within one mile of the King/Drew Medical Center in Watts. All referrals to EDEN are made from Project Support. The EDEN Center was established by a one-time grant of $110,000 from Discretionary Funds from The United Way of Los Angeles. Continuing support is from private donations, as well as an annual $25,000 grant from child abuse prevention (AB 1733) funds directed through the Los Angeles County Department of Children's Services. EDEN has served more than 50 women and 125 infants and toddlers since it opened.

The Children's A.R.K. (Assistance and Relief for Kids) is a Crisis Intervention Nursery and Educational Respite Program that serves drug-exposed infants, their mothers and siblings up to age four. The ARK is a short-term out-patient program that provides crisis intervention and respite to prevent child abuse/neglect and possible removal of the child from its family by helping in crisis resolution and a range of therapeutic services. A 24-hour WARM LINE is a special crisis-intervention feature of the ARK which is co-located at the same site as the EDEN Center. Referrals to the ARK are made from the Los Angeles County Department of Children's Services. The Children's A.R.K. received $149,500 as a 17-month demonstration project from the federal Administration of Children, Youth and Families in January 1989 and accepted its first clients in June 1989. Since that time, it has served more than two dozen families with more than 70 children.

The SHIELDS Family Day Treatment Center will be added to the SHIELDS Projects as a fourth primary program in April 1990. The Day Treatment Center will offer a 7 day/week comprehensive intensive outpatient drug and parenting program for substance abusing pregnant and parenting women who deliver within the Martin Luther King Hospital cachment area with most referrals coming from the King/Drew Medical Center. The SHIELDS Family Day Treatment Center is funded as part of the three-year State pilot project, "Services for Alcohol & Drug Abusing Pregnant and Parenting Women and their Infants", receiving approximately $420,000 per year from the Los Angeles County Drug Abuse Program Office and Office of Alcohol Programs. It will work collaboratively with other components of the pilot project based in South Central Los Angeles, and will annually serve 120 women, their infants and children under four years of age.

Support programs within the SHIELDS for Families Projects include: **The Maternal Psychological Profiles Project**, which provides for a brief assessment of all SHIELDS maternal participants using a battery of selected tests. It is designed to help determine clients' social and academic functioning level, general life skills, psychological status and needs, and special strengths and weaknesses related to vocational skills. Individual service plans are developed with the individual maternal psychological profiles in mind and SHIELDS' overall program design is tailored to meet the general needs of participants based on the overall profile of this population. It is funded with a one-time grant of $10,000 from the federal Office of Minority Health.

The H.E.R.O (High Energy Resources and Opportunities) Program, is a drug/alcohol prevention program for latency age (7 to 11) and early adolescent children (12 to 15 years) of SHIELDS Projects participants. The HERO Program provides after-school and weekend programming that focuses on self-esteem and confidence building, conflict resolution and self-acceptance, and group cooperation and service. Activities are designed to help children therapeutically address issues related to their mothers'/parents' substance abuse and to prevent their own drug/alcohol use. Family, small group, and individual counselling is also offered within the H.E.R.O. Program, which is funded by a $25,000 grant from the Crosby Fund, Winston Salem Foundation through the California Community Foundation.

The **Prenatal Outreach** program is offered to all SHIELDS participants as part of the goal of reducing or eliminating drug use during pregnancy and preventing any subsequent deliveries of drug/alcohol exposed infants to women within our programs. It provides assistance in accessing reproductive health care, maintaining good prenatal care, and making adequate preparation for the birth of a drug-free newborn. It is funded by a $5,000 grant from the March of Dimes, Los Angeles chapter.

172

COUNCIL ON PERINATAL SUBSTANCE ABUSE
OF LOS ANGELES COUNTY, INC.
UAP-CHILDRENS HOSPITAL
P.O. Box 54700
Los Angeles, CA 90054

HISTORY

The Council began formally meeting in 1985, incorporated in 1988 and received its non-profit status in 1989. The Council has held conferences, co-sponsored public hearings, developed protocols and data collection reports and provided trainings to a wide variety of professionals. Initially supported in part by LA County Agencies and Departments, the Council now supports its activities with dues, grants, training and conference fees and donations.

BOARD OF DIRECTORS AND COMMITTEES

The Board of Directors is comprised of fifteen members, elected by the general membership, with four Executive Officers appointed by the Board members. Standing Council committees include: membership, data collection, education and training.

MEETINGS

Council meetings are held from noon to 1:30 pm, the third Tuesday of every month at University Affiliated Programs, 4570 Lexington Avenue (east of Vermont, north of the Hollywood/101 Freeway). Monthly meetings are open to the public, and we encourage your active participation; however, only dues-paying members are entitled to vote.

COUNCIL MEMBERSHIP

Council membership is open to all interested persons, agencies, organizations and institutions.

Membership dues are:
Individual – $30.00
Agency – $60.00

Dues are for the full calendar year January through December.

For Membership Questions, contact:

CATHY HAUER, MS, MFCC
(213) 662-7019

Revised 11/89

THE COUNCIL ON PERINATAL SUBSTANCE ABUSE OF LOS ANGELES COUNTY INC.

MEMBERSHIP INFORMATION

THE COUNCIL ON PERINATAL SUBSTANCE ABUSE OF LOS ANGELES COUNTY

is dedicated to:

- **Educating** the community regarding the special needs of substance-abusing women, their children and their families.

- **Preventing** alcohol and drug use, both in the community and inter-generationally among the families of substance-abusing women.

- **Furthering treatment** which fosters interdisciplinary cooperation and coordination of policies and services.

The Council brings together professionals and community members from both public and private sectors who are grappling with the social and individual problems raised by substance abuse in the perinatal period. This includes issues related to pregnancy, parenting and family functioning addressed by the fields of public health, education, treatment, child development, social work, medicine, law and law enforcement, research, child care, and others.

MISSION STATEMENT

The purpose of the Council is to serve the special needs of pregnant and parenting women and their children by encouraging and facilitating communication among perinatal health care providers, substance abuse treatment programs, the educational system, child care providers and governmental and related social service agencies. Council activities are designed to accomplish these goals by focusing on education and training, data collection/evaluation/dissemination, research, legislative monitoring and analysis, and standards and policy development.

GOALS AND OBJECTIVES

- Compare existing treatment protocols and develop standardized guidelines for hospitals, clinics, and treatment programs to identify and treat substance abuse in conjunction with pregnancy and parenting, and to promote the expansion of such services.

- Develop systems to provide coordinated follow-up services for substance-abusing mothers and their children.

- Sponsor public forums and meetings to educate the community and policy makers about the issues associated with perinatal substance abuse.

- Provide expertise to legislators and other policy makers in the development of programs and services related to perinatal substance abuse and family services.

- Enhance knowledge base for treatment providers working with mothers and children.

ACTIVITIES

Monthly Meetings with special presentations

Conferences, Trainings and Workshops for dissemination of current information

Training Resources to provide expert assistance in the field of perinatal substance abuse

Protocol Development for identifying and treating drug and alcohol related problems among women and their children

Communication Network for information exchange among service agencies

Resource Directory for information and referral purposes in the field

Assistance with development of methods for data collection and evaluation in conjunction with service delivery and research programs

RESOURCES AVAILABLE

Resource Library — Training Programs
Networking Info — Technical Assistance
Video Library

THE COUNCIL ON PERINATAL SUBSTANCE ABUSE OF LOS ANGELES COUNTY

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CHECK: ☐ ☐ **INDIVIDUAL DUES: $30.00** ☐ **New Membership** ☐ ☐ **AGENCY DUES: $60.00** ☐ **Renewal**

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129

THE COUNCIL ON PERINATAL SUBSTANCE ABUSE OF LOS ANGELES COUNTY, INC.

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THE SHIELDS FOR FAMILIES PROJECTS
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Mr. Chairman: Thank you for inviting me to participate in the Subcomittee's Hearing today. As the Program Development Director of three perinatal substance abuse programs in Los Angeles, it is encouraging to know that our nation's leaders in the arena of child and family policy are also deliberating long and hard about program development issues related to drug-exposed infants and their families for our entire nation.

You have in front of you a Summary of the issues I would like to briefly address today in my testimony, as well as a description of the programs I am involved with. I hope you will refer to those materials, and I will be glad to answer any questions you may have after I complete my statement.

First of all, I would like to describe our programs' philosophy and approach as your Committee requested. Although our programs are affiliated with the Pediatric Department of the King/Drew Medical Center in South Central Los Angeles, a major program focus is the mothers, though your topic today is children. This focus is based on our relatively long history of dealing with crack cocaine problems in newborns at Martin Luther King Jr. General Hospital in Watts. And before that, the PCP problem and polydrug problem in general, with the next impending problem of methamphetamines on the horizon; the problems associated with perinatal substance abuse are not limited to cocaine or "crack" and will not disappear after/when the "drug war" is "won". Our approach, therefore, does not focus on one drug, nor even on drug/alcohol problems alone, since the problems related to substance abuse in our community are multiple and must be addressed if families are to be built and maintained. What we learned, often by making mistakes first, is that removing drug-exposed

babies from their mothers at birth is NO panacea. We strongly suggest that programs that are developed to address the long-term issues related to prenatal drug-exposure in children, have a major therapeutic component addressing the women's needs, as well as their children's needs. Without this, it is our experience that the women will very often go on to deliver yet another drug-exposed infant, and the infants, who are very often bounced from shelter care to foster care home, to foster care home to group home, all the while learning NOT to attach, NOT to explore, NOT to trust, and who, according to research, are disproportionately "locked into" foster care (Fanshel) with a much greater chance of moving on to Youth Authority homes, mental institutions, or prisons as they grow into adulthood housed in multiple placements throughout their lives.

As a result of our experience in the early 80's with PCP-exposed infants and County policy that almost automatically removed newborns from their mothers on the basis of a positive toxicology screen at birth, our programs (the oldest of which is just over two years old) put ALL our "eggs in the basket" of the Mother. This approach---that of believing in and working towards family maintenance with about 70% of our identified families---is not only in keeping with PL 96-272 and California's implementation of that law, but appears to both work and be cost-effective.

Even with that philosophy in place however, we initially made major mistakes in program design, primarily because we did not adequately take into account the fact that all persons, but especially women who present to programs as a result of having delivered a drug-exposed infant, do so in various stages of drug use, abuse, and addiction*, as well as

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* We believe this is true because of the nature of a positive toxicology screen at birth which is what usually triggers Child Protective Services, and referrals and/or court orders to treatment programs; in itself, the tox screen indicates very little about the woman's functioning level, degree of drug involvement, or degree of infant prenatal exposure to drugs.

various states of readiness for drug/alcohol recovery, with varying parenting skills. AND their infants present with various degrees of drug-effectedness; not ALL, in fact, in our experience at MLK to date--where about 50 to 60 infants with positive toxicology screens are born each month--not MOST babies appear to be VERY seriously affected. We have therefore learned that we need interrelated programs that operate distinctly, but in concentric circle fashion among themselves, with a continuum of services on differing levels of intensity and time duration. An important key to success in these programs is the initial and ongoing assessment of our families to ensure that the mothers and their index drug-exposed baby are directed into the right program at the right time.

A theme throughout all our programs is that of truly family-focused interventions, with each program including three therapeutic components:

1) the mother as a woman; Because all of our program clients have had drug problems prior to becoming a mother, there is a great need to address those issues that extend beyond her role as a mother. In large part, this component involves Re-Parenting, as well as ongoing evaluation and assessment of the client both in her relationship to drugs/alcohol and other critical issues/relationships in her life.

2) infants/children as individuals, with unique developmental, medical, and other needs; While the mothers are working in the above program component, specially trained staff interact with, care for, and observe the infants and children to ensure that they receive the level of attention, and understanding they need to maximize their potential.

3) mother-infant interactions; Because most mothers in our programs are unaware of child development, and the special care needs of their drug-exposed infants/children, this component is essential to facilitate the mothers bonding and interpretation of their infants' signals, and to help them develop healthy ways of parenting their babies.

All our programs also have both Center-based and Home-based interventions for the following reasons:

Home-based programs serve to (a) lend stability and introduce outside influences in the home setting, which is often disorganized and isolated; (b) afford the staff with opportunities for firsthand assess-

ment of family dynamics and the general home situation in order to better design effective Center-based interventions and help match client and staff realities and expecta-tions (reality testing for staff); (c) implement Center-based learning in the home for continuity of activities for the children and mother; and (d) develop relationships between the staff and the entire family (ie: grandparents, cousins, aunts/uncles, husband/boyfriend, older child(ren), etc.) such that our programs become a resource for the whole family and rapport is established with the mother's network of relationships.

Center-based programs serve to: (a) stop the social isolation that many of our clients have from more "mainstream" functioning society and persons; (b) introduce structure and routine into the lives of the mothers and children and keep the children visible in the community on a regular basis to ensure safety; (c) provide peer support group, opportunities to develop a new network of friends, and interactions with other recovering women in similar situations for encouragement; (d) offer a view of an alternate lifestyle and ownership into a larger process and community than their drug-related activities; and (e) provide a familiar and secure place to turn to in times of trouble, not only for the mother and her infant, but for other family members, including older children.

Throughout all our programs, we never lose sight of the fact that our clients (both mother and infant/child) are in the process of recovering from the effects of a powerful addictive substance that alters functioning levels and changes normal interactions. To help monitor our maternal clients recovery and assess their degree of dependence on their drug of choice, drug toxicology screens are done in a random routine fashion with our clients informing us beforehand of the test's expected outcome to help prevent the test from becoming the measure of truth-

telling in our inter-personal interactions. A positive ("dirty") test does not warrant dismissal from our programs, rather provides cause for increased and intensified program involvement. Only non-participation provides cause for termination from our progams.

What we have learned at this point, is that we must expect relapses (about four in the first year), and we do everything possible to keep the women and/or their children in our programs, to whatever extent they can tolerate, through these experiences. We do what we can to keep them, their children, and extended family within the therapeutic mileau, which means keeping our programs flexible, and also requires a very high level of staff patience, hope, and dedication. Total non-participation is the only cause for termination from the program, and even after termination, we have a number of women that return to try again, and are often admitted in a different program than they were previously enrolled in.

We have also taken the prenatal drug exposure into account in designing our infant/toddler curriculum and follow-up services. Though we provide a range of services and referrals depending on the individual child's needs, we do our best to ensure that all infants and young children in The SHIELDS Projects are followed-up in the high risk infant follow-up clinic at MLK where they each receive developmental assessments, and evaluations by physicians with a high awareness and solid knowledge base regarding prenatal drug-exposure and its consequences in the developing child.

The importance of this service cannot be overemphasized in my opinion, as many pediatricians can miss the early, and often subtle developmental problems that arise with these children, that, if caught early, can be worked with, and often compensated for. For this reason, we would recommend that drug-exposed infants and children be seen in tertiary medical centers or sites with considerable experience and expertise in

identifying and working with these children and their families. It has been our sometimes frustrating experience, that private-practice pediatricians or General Practitioners, who infrequently see these children, and have a low index of suspicion, often fail to recognize the special needs of these children (this often seems to happen in foster care situations), resulting in the children going longer without appropriate interventions that CAN make a difference in their lives and prognosis. For example, we see nearly universal language problems with these children that become quite apparent between 18 and 26 months, but with appropriate interventions, these can be ameliorated and modified. If it's not diagnosed however, it can go on longer to create increasingly serious behavioral and communication problems for these children.

In addition to providing for high quality medical and developmental services for these high risk children (usually funded through State Medicaid and State Developmental Disabilities Prevention Programs), our programs are particularly sensitive to these infants' and childrens' special interaction needs - drawing on their strengths and helping to modify their environment, both at the Center and home, to afford them as many experiences of success, acceptance, and sense of well-being as possible.

What we cannot always do, but know needs to happen is to arrange the marriage of disparate disciplines, for example, maternal and child health specialists, developmental psychologists, probation officers, and the L.A.P.D. and Sheriff's Department. While this might sound strange--and because it does strike people as odd or too foreign, it often doesn't happen--it needs to be occuring as we MUST have professionals from different sectors not only talking to each other (an important FIRST step), but also <u>working together</u> to both educate each other and collaborate in effective therapeutic interventions for this population of often high

risk, multi-problem, intergenerational families. Coalition building is therefore very important, and ought to be encouraged at all levels of both the public and private sectors. A group of concerned professionals and citizens in Los Angeles County have been working since 1985 to build this kind of network, called The Council on Perinatal Substance Abuse of Los Angeles County, Inc., but many more such kinds of efforts are needed throughout the United States, if we are to concertedly make a dent in this unabating problem. (see attached Council brochure)

What you as lawmakers can help ensure is that our society's commitment is, in reality, not only on paper, to BUILD families, not only maintain them. That means providing leadership to the public through your clear commitment not to "give up" on our most needy families and poor children, as well as providing funding for cost effective services that are directed towards community-based progress for mothers and babies together. Such programs are not traditional within the field of alcohol and drug treatment, nor even in the maternal and child health field in this country in which the focus tends to be EITHER/OR mother/baby, but not BOTH. They are also not as easy to develop, organize, implement, maintain, or evaluate as more singular-focused, and centralized programs, but they DO show promise of working.

The Subcommittee will notice that all of our programs to date are outpatient, non-residential programs. The reasons for this are financial/pragmatic and philosophical. The financial/pragmatic reasoning includes the fact that non-residential treatment programs can intensively (7 days/week with both home and Center-based components) serve a mother and her child(ren) for $3,500 - $7,000 per year, whereas the cost in a residential program is generally between six and eleven times as much, and continues to require good outpatient aftercare if recidivism is to be kept to a minimum. (This important aftercare component of residential treatment is

unfortunately often absent, and contributes to the high recidivism rate of inpatient programs.) Given that our programs operate in a high needs community, and began (and continue) at very low funding levels from a combination of private and public sources, we are working hard to develop an innovative, comprehensive model of services that will effectively serve the maximum number of families in Watts.

We further believe that unless our society develops a commitment to eradicating the unhealthy and adverse conditions and attitudes that make the drug problem an endemic one in many of our inner city, minority, and poverty-riddled communities, the families we work with are going to have to learn to live alongside drug dealers selling crack for $2.50 to $10.00/ rock on the streets. For our programs, that translates into the need for "in-the-world" habilitation and rehabilitation programs that not only address our participants' drug problems, but help develop their general life-functioning and coping skills for day-to-day living. As a consequence, we expect the women's "recovery" process to be incremental, since more than "just" addiction is addressed, and their period(s) of involvement currently range between 3 months and 2 years, with varying levels of intensity.

While the annual SHIELDS for Families Projects current budget is $301,500, the <u>average</u> annual cost of caring for <u>one</u> non-medically fragile infant/toddler (age 0 to 4) in a "group home" (congregate care facility with an average of 43 beds/facility) in Los Angeles County is $44,298 (average/month/toddler = $3,691.50), according to data from the California Department of Social Services. For the same dollar amount that SHIELDS is working to maintain and build family units by serving over 400 infants and children under the age of 4 in 275 families (72 of whom received very intensive services), only 6.8 infants/toddlers can be served in the group

home system, which is generally not structured to reunify families, work with mothers, or provide permanent placement for these high risk young children.

While we've heard a lot of bleak testimony today and have learned that there is much YET to be learned about this relatively new population of children and , I would like to tell you that the task of healing, building, and maintaining many of these drug-involved families is do-able, IF we are sincere in our commitment to set aside our prejudices and moral judgements about addictive diseases, explore, fund, and evaluate new program models to adequately assist these children and families, and adopt those that work.

I am heartened that this Subcommittee is prepared to do that and would be privileged to assist in that effort in anyway possible. Thank you.

Senator DODD. Mr. Kroll, we thank you again for being with us.

Mr. KROLL. Thank you, Senator Dodd. I am going to abbreviate this as much as possible and jump into the bold type of my testimony.

Senator DODD. All right.

Mr. KROLL. This Nation cannot afford an institutional solution to the exploding population of children in foster care. Both the human and financial costs are totally unacceptable. Human costs must always come first when discussing the needs of children, but fortunately providing the most humane environment for a child is also the most economical.

Legislators being presented with arguments for institutional care for children should ask: Have these proponents explored ways to professionalize family foster care? Have they committed a fraction of the increased financial resources needed for institutions to providing training, support, and respite care for foster families? Have proponents suggested a room-and-board rate payable to foster families that guarantees a reasonable standard of living for children in the care of the State?

And finally, have the proponents explored all possible sources of family foster care placements, including some nontraditional alternatives, such as relatives, older families, AFDC mothers, and single working parents?

I would predict they have not. I would like to share with you a program that is going on in the State of Michigan at this time which I find quite remarkable.

The State of Michigan has instituted an exciting program entitled LIFE—Living in Family Environments. Legislation sponsored by Shirley Johnson, a Republican Representative from Royal Oak, which is a suburb of Detroit, established a program that places children with developmental disabilities who are residents of State-funded facilities in the homes of public assistance recipients. Through this unique system of employment—and I should add that the mothers are paid $21,000 a year for the total package of care for the children—the foster family is able to enhance their sense of worth and self-esteem as well as their income.

In turn, developmentally disabled children receive the warmth, care, and personal attention they need in order to develop and grow to their fullest potential. The LIFE program is estimated to save the State close to 50 percent of the traditional costs in caring for the two groups.

I think there is a potential model here that we need to look at for caring for children who come into the foster care system who have been exposed to drugs.

This model, and others like it, have a commitment to foster parenting as an important and valued profession worthy of fair wages for provision of critical services. One thing that Congress might do in looking at where children are placed is to use their power of fiscal incentive and to suggest a sliding scale that would provide 60 percent reimbursement to the States for family foster care placement, 50 percent for group homes, and 40 percent for residential facilities. I suggest that somewhat tongue-in-cheek, but I think we need to think about all the possible alternatives here.

I would like to turn to a discussion of termination of parental rights and the adoptability of drug-exposed children. I have to disagree completely with the section of Mr. Mangano's testimony related to adoption. I don't think he knows what he's talking about. His second sentence says, "The adoption process is long, difficult, and expensive." I think he is talking about healthy white children. He is not talking about the kids that we are looking at that may come free for adoption.

It certainly shouldn't be expensive. In many ways the families are going to have to be supported for a number of years or through the whole childhood of the adopted child. And in looking at some of the other points, I just have to disagree with them.

NACAC obviously believes that every child is adoptable. We have seen children in all different categories be adopted throughout the years, and is the basis for that belief. Right now there are waiting lists in some States for families who want to adopt infants with Down's syndrome, families waiting to adopt children with Down's syndrome. They don't have to recruited. They are already in line. The home studies are done.

I think the problem with public policy in relationship to adoption is that we discourage it. In the District, in September, when the series of articles about crack children ran in the Washington Post, the District of Columbia Human Services could not process the calls from the prospective foster and adoptive families that wanted to take care of the kids that had been identified in those articles. The District could not handle the calls.

When they finally had an orientation meeting for those families, 155 families showed up. So there are people out there who are willing to step forward. We just can't process them.

On the other side of the coin, I have a terrible example in North Carolina, where a family who has had in their home now for two years a child who is HIV-positive and has been trying to finalize an adoption, cannot do it because the State of North Carolina, which provides them $1,500 a month in specialized foster care payments, will only, by statute, provide $150 a month if they adopt the child.

So the system is set up to discourage permanence in this case. And there is a family that is ready to adopt a child who is HIV-positive.

We also desperately need to clean up definitions of abandonment, reunification, and reasonable efforts, and establish rational, enforceable legal decision points so children don't continue to linger in substitute care, whether that care is as a boarder baby, in a hospital, or a foster family home. We know at the time of birth that children have special needs. We know the birth mother may not be a viable option for their care, and we know the sooner we provide stability and permanence, the greater the chance to maximize the child's potential.

There has been a program for years for foster conversion to adoptions that has been going on in this country. If we could place children relatively quickly from the hospital who have been abandoned, and there are many of those, into foster homes that would convert to an adoptive home at a later date, we would provide stability for the child and a potential long-term placement.

Some of those families may be disappointed because the child will reunite with the biological mother. But more of them will not. And the child would have stability.

In fact, Congress could do much to urge clear definitions and understanding of reunification: What is acceptable, given a child's sense of time? The Federal Government should consider a policy of fiscal incentives whereby States have a maximum of two years to establish a permanent placement for a child. This is going beyond Public Law 96-272. After that time, States would lose the Federal share of the foster care cost reimbursement.

The final point I want to make, which is on a chart in my printed testimony, relates to the cost of children in care. As you know, there is no data collection in this country for foster are or adoption-related issues. As we have learned today, there is little data collection on anything in this country, which is a comment about something, I am sure.

In my calling around of a survey of States from New York to Missouri to California, I came up with some basic cost factors of the daily rate of different kinds of care that I was able to discover are. Basic family foster care, $8 to $15. Specialized foster care, $15 to $30, which includes supplemental payments for care of children with physical or mental disabilities. The program I referred to in Michigan, the foster care component was about $36 a day.

Therapeutic foster care, which I described in my written testimony, about $40 a day. And residential foster care or residential treatment, $100 a day.

I would like to share the fiscal impact of a policy that would send children into residential treatment or residential care or orphanages. If in 1990 the entire group of 20,000 new children coming into foster care were placed in residential settings, the cost to the taxpayer would be $730 million. If these same children were placed in some combination of the family specialized and therapeutic foster care, at an average rate of $25 a day—which if there are any foster parents in the room they would jump up and down with excitement at that kind of a rate—the cost to the taxpayer would only be $182 million.

Though the costs of caring for these children in foster homes is great, it is significantly less than if the children were placed in institutions.

I would like to close with a personal statement. In 1923, after the death of my grandfather and the nervous breakdown of my grandmother, my father, age 11, and his brother, age seven, were placed in a local orphanage in Minneapolis, St. Joe's Home for Children. The facility still exists as a residential program for emotionally disturbed children and as an emergency shelter. Some kids are there for six months in that emergency shelter.

Children of the 1990's deserve better. They need permanent families, priority attention, and creative thinking and appropriate resources. And as a footnote, they are now considering reopening an orphanage under the name of St. Joe's in Minneapolis. And it was on the news last Thursday night. We don't need that. There are families out there. We just have not figured out the ways to reach them.

[The prepared statement of Mr. Kroll follows:]

PREPARED STATEMENT OF JOE KROLL

Chairman Dodd and members of the committee, thank you for this opportunity to testify before you today. I am Joe Kroll, executive director of the North American Council on Adoptable Children. I represent a large national network of adoptive parents of special needs children. Many of our kids have spent part of their lives in the foster care system--and I regret to say the "system" has often caused great harm to our children.

Things were supposed to get better after passage of P.L. 96-272 in 1980. Instead, the federal government has failed to require compliance with the law, and states have been equally lax. We still have no clearly delineated rules for federal oversight of state-administered foster care and adoption programs--no uniform standards, enforcement provisions, clear definitions of "reasonable efforts," or specific time frames for decision-making.

Put simply, we've had massive failure at all levels of government in protecting and serving our nation's most vulnerable citizens. It's about time we had assurances that the federal and state governments are willing to change, to act out the intent of the law, and to do more than push paper. The system simply isn't working.

And now, the foster care system is being further challenged with a whole new population of children with special needs--medically fragile drug-exposed infants who are already swelling foster care rolls.

Alternatives to Institutionalization

Some have proposed that the extent of the special needs and size of this new population of children leave no alternative other than a return to "orphanages". We are absolutely convinced that this is not true. NACAC believes that children in temporary care should be placed in the most family-like setting possible and that we must expend all necessary resources to recruit, train, and sustain family foster homes.

> **This nation cannot afford an institutional solution to the exploding population of children in foster care. Both the human and financial costs are totally unacceptable.**

Human costs must always come first when discussing the needs of children, but fortunately, providing the most humane environment for a child is also the most economical. Children don't need more institutions. They need creative solutions to bureaucratic problems. They need to have society recognize the importance of their needs and do what is necessary make positive and long-lasting changes in their lives.

Legislators being presented with arguments for institutional care for children should ask:

- Have these proponents explored ways to professionalize family foster care?
- Have they committed a fraction of the increased financial resources needed for institutions to providing training, support, and respite care for foster families?
- Have proponents suggested a room and board rate payable to foster families that guarantees a reasonable standard of living for children in the care of the state?

- Have they explored all possible sources of family foster care placements including some non-traditional alternatives such as relatives, older families, AFDC moms, and single working parents?

I would predict that they have not. Rather, proponents chose the easier route. Agencies responsible for out-of-home care for children often take the path of least resistance and locate existing institutions with available beds. They contract with these facilities whether they are appropriate for the children or not--without regard to financial and human costs.

In fact, we have many excellent alternatives that provide children with care in a nurturing family-like setting. There are numerous model programs that use creativity, fiscal incentives, and more to provide vulnerable special needs children with a safe and caring family in which to spend their childhood.

Let me give you just a few examples:

- Programs that develop and sustain therapeutic foster homes are now found in many areas of the country. These foster homes are similar to non-therapeutic foster homes in that families are evaluated and selected to provide care for a child in their home. However, therapeutic foster families are asked to meet more stringent criteria, are given more education and training, and are monitored and supported more frequently while fulfilling their child care role. Therapeutic foster families also receive a larger stipend, because they are necessarily providing a much more difficult service. Children are placed in these homes because they have exhibited extremely disturbed/disturbing behavior. Therapeutic foster homes provide a cost-effective and nurturing alternative to residential treatment for these children.

- We also must be creative in exploring options for potential foster parents. In many cases parents whose children have all left home, or single parents, or relatives make excellent resources for special needs children. Creative public policy can help take advantage of their skills.

The State of Michigan, for example, has instituted an exciting program entitled L.I.F.E. (Living in Family Environments). Legislation sponsored by Shirley Johnson, a Republican Representative from Royal Oak, established a program that places children with developmental disabilities who are residents of state-funded facilities in the homes of public assistance recipients. Through this unique system of employment, the foster family is able to enhance their sense of worth and self-esteem as well as their income. In turn, developmentally disabled children receive the warmth, care and personal attention they need in order to develop and grow to their fullest potential. The L.I.F.E. Program is estimated to save the state close to 50 percent of the traditional costs in caring for the two groups.

- New Jersey has launched a pilot program to find specialized families for AIDS and drug-affected infants unable to leave hospitals because of lack of caregivers. This Special Home Service Provider Program allocates a flat rate of $500, paid for up to three months, to guarantee space in a providers' home for a maximum of two medically fragile infants. Upon placement of a child, the care rates increase to $900 a month ($1000 a month for a child testing positive for the AIDS virus but showing no symptoms; and $1200 fora child with AIDS symptoms). There is extensive pre-service

and regular in-service training and support for providers, and families are required to adhere to comprehensive standards of care for these at-risk babies.

> **One important common thread in each of these models is a commitment to foster parenting as an important and valued profession, worthy of fair wages for provision of critical services.**

Congress has an opportunity to make a strong statement about the importance of a family-like setting to a child by legislating financial incentives biased against the institutionalization of children. For example, a sliding scale could provide 60 percent reimbursement to states for family foster care placements, 50 percent for group homes, and 40 percent for residential facilities.

Timing of Termination of Parental Rights

The appropriate timing of termination of parental rights has been an ongoing issue in foster care for many years. The new population of drug exposed infants flooding the system are creating an even greater need for more effective public policy in this area.

I would like to quote from an article entitled "Children of Crack" by Douglas Besharov, a resident scholar with the American Enterprise Institute. It was published in the Fall 1989 issue of *Public Welfare*, the journal of the American Public Welfare Association.

> Adoption should be a real option for children whose parents show little prospect for improvement--even though this means terminating parental rights. Unfortunately, legal rules and social attitudes make it exceedingly difficult and time-consuming to terminate parental rights. In New York City, 60 percent of the babies discharged from hospitals to foster care--mostly crack babies--were still in foster homes three years later. Another 30 percent had been returned to parents or relatives. Only 7 percent had been adopted.
>
> Even in the most threatening cases, few children are quickly freed for adoption. One crack baby's father had served four months in jail for killing the boy's baby sister six months earlier. The mother, who was frequently beaten by her husband, was in touch with the foster care agency only sporadically. She subsequently gave birth to another cocaine-exposed child; three years later the child still lived in a temporary foster home...
>
> Laws and attitudes must also change. No one likes to give up on parents, to label them as "hopeless," especially since many are themselves victims of broader social problems. But these children deserve a chance--even if we must assume long-term responsibility for their care and upbringing.

NACAC agrees completely. Again, I speak for a national network of parents who have adopted special needs children.

> **This new population of medically fragile infants, even with their extensive needs, ARE adoptable.**

Drug-exposed infants are similar in many ways to other groups of disabled children--children who are successfully adopted as long as appropriate family preparation and

follow-up support are in place. (Currently in many states there are waiting lists for infants with spina bifida or Downs Syndrome.) We certainly need to expand our base of knowledge about the impact of prenatal drug exposure, its effect on development, the unknown potentials for these children--and share that knowledge with those able and willing to parent these kids. But permanent, caring, adoptive families are out there. We simply need to identify them, prepare them and support them, and promote public policy that facilitates these placements.

Also, children entering foster care from families who seem unlikely to be able to parent them again can be placed in "foster/adopt" families. These are families who have been screened and trained to parent a child with the understanding that if in fact parental rights are terminated, they will proceed to adopt the child. This approach to social work practice assures a child of an advocate during his or her stay in foster care. And an initial placement with an appropriate and potentially permanent family means a less traumatic outcome for the child. Programs for such "legal-risk" placements are common throughout the country.

Still, public policy often works against permanency. For example, a family in North Carolina has been pursing adoptive placement of a three-year-old who tested HIV-positive. The family is experiencing difficulty regarding subsidy payments. While this child (who at age three has never lived outside a hospital) lives with them as a foster child, the family receives a $1500/month specialized foster care payment. If the family adopts the child, state law currently limits the maximum adoption subsidy to $150/month.

We also desperately need to "clean up" definitions of abandonment, reunification, and reasonable efforts, and establish rational, enforceable legal decision points so children don't continue to linger in substitute care, whether that care is a boarder baby ward in a hospital or a foster family home. We know at the time of birth that these children have special needs; we know that birthmother may not be a viable option for their care; and we know that the sooner we provide stability and permanence the greater the chance to maximize the child's potential. Where conflicts exist between birthparents' rights and the rights of the child, let us err on the side of the child and do all we can as quickly and efficiently as possible.

> **In fact, Congress could do much to urge clear definitions and understandings of reunification--what is acceptable given a child's sense of time. The federal government should consider a policy of fiscal incentives whereby states have a maximum of two years to establish a permanent placement for a child. After that time states would lose the federal share of foster care costs.**

Fiscal Analysis

For once in human services, the most effective public policy alternatives are also the least expensive. Institutional care for children is still the most costly form of out-of-home placement. Costs of "boarder babies" in hospitals--just minimum custodial care--can average $9,000/month. And the children may literally never see the light of day.

Residential care is also extremely expensive at an average of $100/day. There are certainly times when limited stays in residential treatment are both necessary and helpful. But, we must save residential placements for the very troubled children who really need them. In addition, building such facilities, or contracting with them for a certain number of beds results in a fiscal incentive to fill them, whether or not they are the true placement of choice for the children involved.

The majority of children in out-of-home care are in foster homes (last estimated at 66% in 1986.) In spite of popular perceptions, foster families are still stepping forward. In Minnesota, for example, between 1986 and 1988, the foster care population grew from 5,616 to 6,516 children. Almost all of the increase (92%) was absorbed by family foster care placements.

As you know, there is no national data collection system on children in out-of-home care. Consequently, numbers listed below are not true national averages. Rather, they are based on a sampling of programs in five states.

Estimated Daily Rates for Costs of Out-of-Home Care
1990

Categories of Care	Daily Rate
Basic Family Foster Care	$8-15
Specialized Foster Care (Supplemental payments for care of children with physical or mental disabilities)	$15-30
LIFE Foster Home (Michigan) (Does not include AFDC transfer)	$36
Therapeutic Foster Care	$40
Residential Foster Care	$100
Hospital Placement	$300

The fiscal impact of decisions concerning children's living arrangements while in foster care can be staggering. For example, in 1990 the foster care population will increase by an estimated 20,000. If all 20,000 new children coming into care were placed in residential settings the cost to the taxpayer would be $730 million per year. If these same children were placed in some combination of family, specialized, and therapeutic foster care at an average of $25/ day, the cost to the taxpayer for these children would be $182 million per year. Though the costs of caring for these children in foster homes is great, it is significantly less than if the children were placed in institutions.

Conclusion

In 1923, after the death of my grandfather and the nervous breakdown of my grandmother, my father (age 11) and his brother (age 7) were placed in a local orphanage, St. Joseph's Home for Children. That facility still exists--as a residential program for emotionally disturbed children and as an "emergency care" shelter. (Some kids have been in "emergency" shelter six months or longer.) Children of the 90's deserve better--they need permanent families, priority attention, creative thinking and appropriate resources. There is no time to spare.

Senator DODD. Amen. That is excellent, excellent testimony. We are not going to let you get out of town without giving us some thoughts on how we might translate some of those ideas that you have talked about into Federal legislation. We deal with the special-needs adoption legislation here in this committee. I think there are some excellent suggestions in your testimony in terms of the incentives to States. We can do an awful lot to provoke a far better response in the States based on what we contribute to that effort. So I really appreciate your testimony.

Mr. KROLL. Thank you very much.

Senator DODD. We appreciate what you've done.

I have a number of questions here for you, and then we will let you get going.

Again, we thank all of you. I have a question for you, Ms. Coletti, first. We put up some additional new funds, substantial funds in the drug treatment programs here in Congress, including, of course, reducing the waiting lists for treatment programs. I would like to know whether or not you have seen this new infusion of funds getting down to the program level, or are you having a problem getting the funds out of the States?

Ms. COLETTI. Yes. I am glad you asked that, Senator Dodd, because we are having trouble getting it out of the States.

You know, the Operation PAR, to help pay for PAR Village, qualified for $1.3 million. And that was in October, and we as of my board meeting two days ago had yet to receive that first cent even though we had expended over $300,000 of money, going to the bank and borrowing it and so forth.

What happens is those Federal dollars come down to the State and then, you know, you get the State politics involved in it, you get the Governors' office, you get your health and rehabilitative services office, and by the time that happens it takes up several months.

So I would encourage the Congress to find some mechanism either for direct grants and bypassing the States—and I know the State's rights issue and so forth—but it's very problematic, and I think somebody has got to take a heavy hand on the issue or programs such as ours have a very difficult time eventually getting that money.

Senator DODD. Well, of course, the argument here is they wanted that money to go to the States. You know, a lot of us tried to get the money to go directly to the programs. But there was such objection politically so that everything is supposed to go to the States.

Ms. COLETTI. I understand. The Governors, obviously. But there has to be, maybe, some proviso language that needs to go in—and I am fairly familiar with the language because we tracked it—but there has to be something done that programs who qualify can get that money, especially this wait list money, because this will take up—we have a waiting list of 330 people to come in our residential treatment center.

Senator DODD. Yes.

Ms. COLETTI. Three hundred thirty people calling in every day asking if they have a bed.

Senator DODD. Yes.

Ms. COLETTI. And we have given first priority to pregnant substance-abusing women. PAR Village will accommodate 85 new beds. Now, we have gone to the bank and borrowed money at eight and nine percent interest, and we are just a community-based organization, hoping and betting on this Federal money coming down. You know, we have really had a very difficult time, and we have a very good relationship with our State.

Senator DODD. Yes. Have you been in touch with Senator Graham?

Ms. COLETTI. We have been in touch with Senator Mack's office and we have been in touch with one of our congressman. I was unable to get in touch with Senator Graham at the time.

Senator DODD. Well, I am going to mention it to him. I will see him later in the day.

Ms. COLETTI. I would really appreciate it. He knows my program very well.

Senator DODD. Yes. And that you are having that trouble. If that is all right with you?

Ms. COLETTI. That's fine.

Senator DODD. I will have him get in touch with you.

Ms. COLETTI. That's fine. We have threatened a lawsuit, we've threatened to go to the newspapers. We threatened embarrassment, shame, whatever it takes to get the money. [Laughter.]

Senator DODD. I like that.

Let me ask you and Ms. West something. You know, you're preaching to the choir here; I guess we all are to some extent in agreement on these things. But the whole idea of networking and so forth, is just so fundamental I don't know why there is even the debate about it. It almost seems like a waste of Federal money to hold a hearing about it, it seems to obvious.

And yet we seem to have difficulty getting States agencies, getting local agencies, to really get involved in that. I must say in my own State efforts to coordinate seem pretty good. I think they're working fairly well, and maybe in a lot more States it is happening much more than I think, but I am hearing too often that it's not.

I mean I wouldn't put up with what many of these women face. None of us at this table would put up with it where you'd spend all day going from one place after another. You're just not going to do it. I don't care if you had all the money in the world and the time in the world, you're not going to do it. And if you had a chauffeur-driven car to take you around, you wouldn't do it.

The idea that someone who doesn't have transportation, doesn't have a lot of time, is going to go to 15 different doors, knocking on them, trying to find out what works, is absolutely ludicrous. And it's a tremendous waste of money. It's a tremendous waste of human talent.

Now, the problem is how do we get it done? I have a bill that provides financial assistance to States for coordination and networking of services. But I am not convinced that even if we provide the money it's going to happen. There seems to be this territorial outlook, almost medieval kind of view that what's mine is mine and anyone who gets close to it is somehow going to detract from the quality of the program—or my control over it. I think this is frankly, being more honest about what we're dealing with here.

Now, somehow or another we've got to break that way of thinking I am very interested in hearing what you think can be done to help kick those doors open and provide some clearinghouse mechanism where people can go and do what you and I now do at our banks and everywhere else: We want one-stop shopping for people in these programs. We've got to figure out a way to do it, and I am very interested in hearing how you think that could be done.

Ms. WEST. Yes, I can begin to address that. And I think you're quite right that there is a tremendous amount of territoriality and sort of animal behavior going on in our staking out our turfs here.

But I think that the plague that has been with us so long and still is there is the categorical funding issue where you have so much vertical funding of different programs, and I think that there really is room for financial incentives to make programs co-locate and out-station their workers in different sites.

I think, for example, that the community hospitals are key places for that, where we are identifying the women at delivery as drug-exposed, and if we lose them from that site, we are going to have a harder time finding them in the community later on. I think that is one of the places where we could insist that out-stationing of department of children's services workers and other kinds of groups work together.

In California we now do have a pilot project, and we are in a similar position as Florida as Ms. Coletti has just referred to in terms of the problems of getting the money out of the State Government because they're working with four different departments who have never spoken to each other, apparently since time began, and therefore have had a really difficult time in trying to move that to consensus at the State level to move the programs down to the county.

We have managed in our little community to at least get ourselves talking among ourselves with some, in fact, of the money from Public Law 99-457 on high-risk infants and early intervention programs, through that bill, in terms of moving the 0-to-3-year-old intervention.

Senator DODD. Yes.

Ms. WEST. However, I do think financial incentives can make a difference if you insist that money would only go to programs that co-locate and that insist on—the phrase we are now using is "out-stationing" in one site.

And I completely agree with you that our mothers cannot and will not go to seven different programs in the course of a week let alone in a day. So it's critical.

Senator DODD. Do you have a comment?

Ms. COLETTI. You know, I think this issue, Senator Dodd, has traditionally the substance abuse community, mental health, alcohol have worked in their arena and then the perinatal issues have been in another arena. And this cocaine-exposed baby has caused the need to bring a lot of different groups and providers together.

And what we did in our State is Operation PAR sponsored a substance abuse—we called it the Innocent Addict Conference. The first conference, we had about 200 people come from throughout the State. The second conference, we had 400. And just this past February 6 we had 600 people come to a conference, and it was all

dedicated to—of course, we had wonderful speakers and presentations—but it was dedicated toward networking. And it's phenomenal how the WIC persons and the county health departments and all the other providers are coming together and beginning to network.

So one of the incentives may well be to provide the funding for each State or encourage each State to have a perinatal substance abuse conference for the purpose of networking. A lot of these people have never been in the same room at the same time.

Senator DODD. Yes.

Ms. COLETTI. This might be helpful.

Senator DODD. Well, it might be. I have to be honest with you, I think Ms. West put it candidly. You put dollars and cents up there on the table, and they realize they're not going to get cooking unless they get together.

Ms. COLETTI. That's very true.

Senator DODD. I think unfortunately that would be the case.

I have a related question for both of you. And jump in here, anybody. I am asking the two of you, but if you want to comment on this, Ms. Tice or Mr. Kroll, please don't hesitate.

I am concerned about the fact that we are just beginning to get information. We know what's happening to the low-weight infant at birth. We know about all of the problems immediately they are occurring. But since this is rather a new phenomenon, now we get some sense that there are problems even after they go home. We are already getting some indications of neurological difficulties that I didn't even mention.

From my own experience, my sister, who teaches in an inner-city school in Hartford, Fox School, the largest elementary school in the State of Connecticut, started out as a Montessori teacher, training with the school in Greenwich, CT back in the 1950's.

Now she is telling me—she works in early childhood development programs—that just watching what's happened over the last few years is quite disturbing. Where once she would have two or three kids that had problems and 15 or so that were fine, she is now ending up with the 15 who are troubled and she has two or three maybe that are OK.

So she is seeing the increase in troubled children. My phone rings off the hook—and I am not exaggerating—at least once a week, and she fills my ear with what's going on at just this one site in Connecticut.

In my visits to Head Start programs in Connecticut and elsewhere, I am wondering how effective we are in picking up these problems that are now going beyond what we know medically are some of the difficulties with these children. What can be done to start—it goes back to the networking, I guess, a bit—to gather this kind of data so we get some sense of what we're dealing with here?

Ms. WEST. Well, I will go ahead first and let Ms. Coletti share some information.

One of the things I think is critical——

Senator DODD. And by the way, I should say you can also jeopardize the programs that will be seeing these children. We are reauthorizing Head Start, but we are going to reauthorize it, I presume, basically on the notion that Head Start needs more money

because there are more eligible people out there and so forth, but using a program structure basically along the lines of 25 years ago. Here you've got this whole new set of problems that these Head Start programs are going to have to confront, and we don't have a lot to work off of. I am guessing that these people are going to start facing serious problems that they never imagined they would encounter in a Head Start program.

But I think my colleagues are apt to think I am crazy when I start talking about this problem in the context of Head Start, because there are no data to support this assertion other than my ears getting filled by a sister and stopping off at Head Start programs that tell me about it.

Ms. WEST. I think that is very important to say that there isn't any data right now, and I think that we need to be very cautious. While I am very glad you convened this hearing, I am very concerned about our labeling children crack babies or crack children or whatever. I think that's very dangerous.

Senator DODD. Yes.

Ms. WEST. There are varying levels of drug exposure. There seem to be varying levels of permeability, if you will, in which the children respond differently. We know from a neurological and embryological basis that there are different effects that occur to the developing fetus or developing embryo, depending on the kinds of drugs that were taken. There are neurologic sequelae.

I think that what we can say is in the children we work with, which are really age zero to about four, although we followed some kids up to age six, mostly PCP-exposed, are a lot of universal language problems that come in between 18 to 36 months, where you really begin to see those problems develop.

One of the things we think we need, and this is one professional that hasn't been paid attention to on a program level, are audiologists. Since language skills really need to be developed between age zero and two years old, three years old, we find that there are many hearing problems that these children are having that don't get picked up. And if that is the case, language just does not come in later on, which contributes a tremendous amount of problems in behavioral interactions and other kinds of interactions with the adult world.

In other of our programs we have seen that the children have real problems in transitioning. They are moving from one activity to another. Therefore, those things need to be done in a different kind of a manner.

I think that one way that we can begin to stem this is to make sure—I talk to many, many juvenile court judges and recommend that if they've only one referral to make and drug treatment just is as unavailable in most places as it is in Los Angeles, don't even waste a referral on drug treatment, make sure that this child is referred into a high-risk and follow-up program and that therefore in those centers, which most places have funded through Medi-Cal right now—I am being very pragmatic about looking at what is funded already, not assuming that there is going to be other help necessarily coming down, that there will be somebody that can evaluate that child and make sure that appropriate referrals are made.

I think that Head Start is going to need an influx of different kinds of specialists, and we are going to be needing more networking on a kind of general basis.

Senator DODD. OK.

I wanted to ask a question of you, Ms. Tice, our resident expert here today on how these things really work. We listened to a lot of people talk about what they think will work. What, in your view, is the best way to get people into prenatal care? You've talked about your experience, but I presume you have known other women who were either are substance abusers or were substance abusers. What, in your view, generally would work? You heard people talk today about mandated programs and voluntary programs and so forth. As a practical matter, if you had to design a program to maximize getting people into these programs, what would you recommend to us?

Ms. TICE. Well, Senator Dodd, I believe that education is knowledge. OK. So if these women know what's really going to happen to them, you know, what's happening to them and to their baby, then maybe they would be more willing, because a lot of women are ignorant of what drugs and alcohol actually does to the fetus.

Senator DODD. How do you get that information to a woman who is out on the street working tonight in Washington? How do you reach her?

Ms. TICE. Billboards, television.

Senator DODD. What affected you?

Ms. TICE. What affected me?

Senator DODD. What affected you? Do you remember anything particularly? Did you see something that sort of grabbed you— aside from your family or others— that caused you to say this is something I have to deal with?

Ms. TICE. Television commercials.

Senator DODD. They did?

Ms. TICE. Yes. Commercials and billboards and little pamphlets. But I was a street person. I did hang out on the streets, you know, I was out there all night. And if someone had come up to me and said, "Hey, you need to go in treatment," I would tell them where to go. I wasn't ready to listen.

So, you know, if these women aren't ready for help, then we can't make them. When they're ready, they will find help. They will go to a county health clinic, they will go somewhere.

When I was in St. Petersburg and I was ready for treatment, I just walked into a hospital and said, "Hey, I need some help."

Senator DODD. Well, what about what we heard Dr. Chasnoff say today about, "Well, listen, even if they're still on drugs, if you can get someone in a program and you start them dealing with some of these issues, you increase dramatically the likelihood that that infant is going to be better off"?

It sounds to me that maybe mandating that you get into a program whether you like it or not and particularly where you're going to receive some treatment is going to, if it doesn't do much for you, it may do something for your child. So why not mandate that a bit?

Ms. TICE. I believe that could work. It could work for the length of time that the woman is pregnant. But as Ms. West said, talked

about, she would probably relapse until she gets it in her mind that she has a disease, that the addiction is a disease.

Now most pregnant women, they do care about their babies, and they would want them, but what really scared me was the thought of having a disformed baby, a deformed baby or retarded baby. I didn't want that because that would have been more burden on me and the system, you know. So that's why I stopped. I stopped when I was six months, and before that I could not stop. I wanted to, but I just couldn't. So finally I went into the treatment center, as I mentioned, and stopped.

If I had to design a program—you asked me that—I would offer seminars and talks, you know, and at a low-pressure type of situation where you just come in and you just see what you want to see. I wouldn't force them. And once they're ready, I believe that they will do something about it.

Senator DODD. Yes.

Ms. TICE. You know, here has to be more places available because in St. Petersburg they closed down one, the one I went through. They closed it down. So now on the south side, where most crack-using, drug-using women are, there is no place that they can go.

Senator DODD. Yes. Even if they wanted to.

Ms. TICE. Yes. Even if they wanted to.

Senator DODD. There are statistics about how many people actually walk in on their own. I think with infants, you're right, you have an added incentive there for the reasons you have cited as well as others that act as a significant motivating factor.

But in the absence of that, I always wanted to believe that there were a lot of people out there who were desperately trying to get off this stuff and looking for a way to find a good treatment program. I am being told by people who are in the field that that ain't exactly the case, that there may be some, but frankly it's often because a family member, a spouse——

Ms. COLETTI. Courts.

Senator DODD. A court or someone else—says, "You ain't coming back in the door again. I'm divorcing you. I'm leaving you," or something else along those lines. And that really scares people-the prospect of losing something that is almost as important if not more important than the habit. They tell me it is this kind of motivation which causes people to get into these programs, that there are not a lot of people wandering around knocking on doors to enter a treatment program.

Now, you can correct me if I am wrong. But that is my information.

Ms. COLETTI. Yes. I think that is not quite accurate, in that many communities just do not have facilities available to treat women.

Senator DODD. That I accept.

Ms. COLETTI. If we accept that premise——

Senator DODD. I accept that.

Ms. COLETTI. [continuing]. Then we accept the fact, and I accept the fact, that many times women do need—anyone with addiction, men or women—do need coercion. I mean I do not buy into the philosophy and research does not demonstrate this that you have to

bottom out before you respond to treatment. We just don't espouse to that.

What we do believe and what we do find is frequently statistically we know that 70 percent of the women that get involved in drugs, especially the crack cocaine issue, got there by virtue of her man or her significant other.

Forty percent of the women who go into treatment go there by virtue of her mama who just says, "You are going into treatment one way or the other. You're going."

Usually what that means is mama has to take care of one or two or additional children while that daughter does go into treatment.

But I think that there again, if there isn't a mother, if there isn't an aunt or there isn't someone in the community to take care of that child, the mother will go into treatment for just 10 days or maybe even shorter, she will detoxify, and then she starts looking fairly healthy, and then whoever the caregiver is of her other children will say, "Look, you're healthier and look better than I do. Come out of treatment and take care of your children."

So that is one of our incentives to start the program where we have children and mothers in treatment and take a look at the retention rate. We think it will be remarkably more than in other programs.

Senator DODD. OK. Well, that is helpful.

Ms. WEST. I think that is our experience as well. If I just might add that we have had a very interesting response from our mothers who, to follow up on Ms. Tice's comment about education, many of our mothers were afraid that they would deliver a child that would look like a thalidomide child, if you will, that had physical deformities.

The fact that they didn't have any physical dismorphology meant to the mothers that they didn't have any problems and they felt that they had escaped the problems. I think it's really important, therefore, that when you put billboards up, if this is what we're going to be doing, that you not necessarily show a child that is rigged up to a gazillion different things in an ICU but that in fact you mention the neurological sequelae, which are much more subtle and that that is a whole different kind of educational process.

Senator DODD. Yes.

Ms. WEST. But I think many of our mothers don't understand what some of the ongoing problems are on a level that are not physiologically obvious.

Senator DODD. But it is obvious in the intensive care unit. Well, now we've heard of these roundups of women on the street. If we could have something where we could just gather a group of women, put them in a van, drive them down to Children's Hospital here, and take them up to the ICU unit and leave them in there for an hour, then put them back out on the street and say, "Now you figure it out."

I mean, it doesn't have to be long or involved, but I think it would help if women could see these tiny infants you're likely to produce. I am not advocating roundups; I realize that would get every ACLU club in America down my back. [Laughter.]

But the idea of if you want to do something profound for people, just take them and let them see that. The likelihood that you're going to have a child in that situation is——

Ms. COLETTI. I will have to talk about Mayor Barry, I will have to talk about Dexter Manley.

Senator DODD. Yes.

Ms. COLETTI. I will have to talk about all of these athletes that have died of drug overdoses, knowing full well what crack cocaine and what cocaine did to their system.

Now, you know, these women are no different than these people, these other people that used crack cocaine.

Senator DODD. I disagree with you. I think the thought that you are going to have an offspring, that you're carrying a child—well, who am I to be talking about it as just a male—but I think for a woman in that situation, knowing that she is going to give birth, has to make a difference. Kids looking at sports idols I think is one thing, but a woman about to give birth to her child—I just can't believe that it doesn't have a more profound effect. And you're saying it doesn't?

Ms. WEST. I don't think so. I mean I think that if you will understand addictionology—and we've been trying, you know, to cram ourselves into learning about it, the powerful addiction that many of our women coming in—there are different stages also in the whole addictive process, so not all of the women are at the stage where they are absolutely in a maintenance phase where they absolutely have to have the drug. But I don't think it absolutely overwhelms them.

And the other piece that is dangerous with that is that then when their child is not born in an ICU at 32 weeks with all sorts of problems——

Senator DODD. Yes, that's true, too.

Ms. WEST. [continuing]. Which is the experience that most of our mothers have, that the children are born relatively apparently physically healthy in appearance, but that does not mean—they really have lesions throughout their brain and other kinds of urogenital problems and other kinds of things that you see. But you will then be discredited. I mean we don't want to do the same kind of thing that we did with "Reefer Madness" in the 1960's and 1970's. I think that's dangerous.

Ms. COLETTI. And this just applies to crack cocaine. I have worked in addictions for 20 years. I have seen mothers come off of heroin, I have seen them come off of alcohol, I have seen them stop smoking marijuana. I have seen them stop using all substances when they found out they were pregnant—unlike crack cocaine.

Senator DODD. Yes.

Ms. COLETTI. It's a very, very serious, highly addictive substance.

Senator DODD. On that happy note, Mr. Kroll, there have been some reports recently that at least one national adoption organization is actually advising prospective adoptive parents not to adopt drug-exposed children because of potential costs and behavioral problems.

One, I want to know whether or not you're aware if that is true.

Mr. KROLL. I am still trying to find out who that is. It is not us, obviously.

Senator DODD. I will quietly give you this name afterwards.

Mr. KROLL. I can guess.

Senator DODD. You can take a look at it.

I wonder if you might share with us a little bit about how we might educate potential parents so that they know that drug-exposed children can be adopted successfully. Obviously, what I mentioned to you at the outset was what the Federal Government can do to facilitate the adoption of at-risk children.

You mentioned some of the things, some of these incentives, I think. I am very intrigued with this piece of legislation in your State that you adopted, utilizing welfare families.

Mr. KROLL. In Michigan.

Senator DODD. Yes, Michigan. I think that is really interesting. How long has that been in place?

Mr. KROLL. Since 1987.

Senator DODD. That is a couple of years now. You ought to be able to start getting some data from that program.

Mr. KROLL. It's a very small group of people. It's only 14 families. But it's a positive experience.

I believe in the copy of the testimony that I sent you, I included a clipping on the program.

Senator DODD. You did.

Mr. KROLL. And it is fascinating because what you've done, and I think this is something that we really have to look at, who are the families and, in particular, who are the women who will serve society best by being parents? And there are a lot of women, for example, who are by their financial condition on welfare who are very good mothers.

Senator DODD. Absolutely.

Mr. KROLL. And let's take advantage of that. And that is an income-redistribution issue that is going to drive people crazy, but in Michigan it was proposed by a Republican State legislator from the suburbs of Detroit.

Senator DODD. That's shocking. [Laughter.]

Mr. KROLL. And they've got—I think you can turn it around and not make it a partisan issue.

Senator DODD. But you couldn't resist mentioning what party it was.

Mr. KROLL. Sorry about that.

The other category of people that I think we need to look at, and maybe not so much for this population but for some of the older kids, is families where the parents are in their 40's, 50's, and the kids are grown and mothers are going back to sell hamburgers at McDonald's because that's the only place they can get a job, and we need workers during the day, when they were mothers for 20 years.

Senator DODD. Right.

Mr. KROLL. We are not taking advantage of them.

The other thing we are not doing, if you look at the family foster care model, the families who have children in foster care subsidize the State care. They do not get paid the average poverty rate, I believe, for maintaining the child in care in most States. What we have to do is make the decision that instead of spending $100 a day on an institution, we are going to raise the rates, we're going to

provide training, we're going to provide respite care, we're going to tell people when we find out what these kids are all about—and I think that that's a danger—but I don't want to wait 18 years for a study of Ira Chasnoff's 35 kids.

Senator DODD. No, no, no. We've got to move. Yes, we've got to move.

Mr. KROLL. You know, we've got to do it now.

Senator DODD. Yes.

Mr. KROLL. And I am not suggesting he was thinking that way, but we can't study this one to death. We have to identify some categories of kids.

I think that was what was most successful with the Down's syndrome children is over a period of time people got to understand what that child's capabilities were, what the medical problems were, the heart defects, how many hugs per day you had to give the child, and said, "I'll do that." And I think we have to do the same thing with these children and make those decisions and find the families and place the kids immediately, you know, if they're abandoned. I am not saying take children away from mothers. But if they're abandoned, if they're in foster care, put them in families right away.

Senator DODD. Yes. I have always been curious—maybe you can't tell me this right off, and I realize there is no absolute profile—about the profile of the adoptive family. I have often said rhetorically that it's basically working folks, in many cases, who take on these children.

The very, very affluent don't, it seems to me. And the desperately poor have a hard time doing it, but they would like to. So a lot of times adoptive parents have to be that group of working people crowd who have the hardest time making ends meet. They've got two incomes, but they're not driving Volvos and going off to Aspen on holidays. Benefits like parental leave and so forth, where you make it possible for these families to do what they want to do, are helpful in this area.

Have I been wrong in saying that?

Mr. KROLL. No, absolutely correct. One of the places where children are listed every week that are legally free for adoption is the National Inquirer. Every week there is a column in the National Inquirer. And I think that says something about who may read the National Inquirer and a targetable population.

Senator DODD. It may be the only worthwhile thing that magazine does. [Laughter.]

Mr. KROLL. Well, you know, every week when I go to the grocery store I try to find the kid that's in there.

Senator DODD. Sure, a likely story. You read that National Inquirer, we know why you're reading it.

Mr. KROLL. It's a long line at the grocery store. [Laughter.]

But it's right. I think it's middle-class families and lower-middle-class families. It's also larger families. And it is, I think, situations where you have women, by and large—and I tried all these remarks out on my wife to make sure I am not being too sexist here—but women who have said, "What I really want to be is a mother."

Senator DODD. Yes.

Mr. KROLL. "And I have had some children, I have borne some children, I have some foster children, I will adopt some children, but I want to be a mother."

Senator DODD. Yes.

Mr. KROLL. And those are middle-class, those are working folks. And I think making it a reasonable remuneration for some of the kinds of kids we're talking about is a very reasonable approach. And I think that study, the Michigan one, needs to be advertised.

Senator DODD. Absolutely. We ought to do that.

Mr. KROLL. Show it around the country.

Senator DODD. We are going to get her to come in here and take a look at the approach.

Mr. KROLL. I have more information, I think.

Senator DODD. Why don't you help us get some of that? That would be helpful to us.

Yes?

Ms. COLETTI. Senator Dodd, we have a contract through our OSEP grant to provide foster care for some of our babies whose mothers are in treatment, and we are in by our State, we are only allowed to pay $11 a day to reimburse these foster care parents to take our babies. And you know, they just can't and won't do it for that.

Senator DODD. No.

Ms. COLETTI. I mean it's just impossible.

Senator DODD. It's impossible.

Listen, you have all been great, and I have kept you an awful long time. We have gone far beyond the time we had hoped, and we've put you through it. But it has been very helpful, too. We have received some good information here from you, at least to get us pointed in the right direction on some of these issues.

Mr. KROLL. If I could suggest an item that is totally out of my area of expertise, but as we close military bases, maybe we could convert them to treatment centers that are lacking, or maybe the Department of Defense could.

Senator DODD. Well, they're talking about turning them into drug places.

Mr. KROLL. Prison camps.

Ms. COLETTI. Boot camps. Campuses. Campuses.

Mr. KROLL. Maybe just move the money.

Senator DODD. Having spent 13 weeks at Fort Dix, NJ, I could tell you how that——

Ms. COLETTI. People have to understand addiction and rehabilitation and treatment before they start talking about boot camps.

Senator DODD. I agree.

Thank you all.

[Additional statements and material submitted for the record follow:]

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March 16, 1990

Senator Christopher J. Dodd
SR-444 Russell Senate Office Building
Washington, DC, 20510-0702

Dear Senator Dodd:

We at United Way of New York City are pleased to submit testimony on the subject of drug exposed babies for the hearings held by your Children, Family, Drugs and Alcoholism subcommittee. This is a critical area and we thank you for your leadership in bringing attention to the issue.

We have sent our testimony along with that of a program we help to fund that addresses some of the problems of these children and their mothers here in New York City. The submission of Project Return Foundation, Inc. will provide vital details from the front line.

We have also enclosed for your information a package on the priorities we have set for our organization as mentioned in our testimony. If you have any questions or if we can be of any further help on this issue, please let us know.

Sincerely,

Ralph Dickerson Jr.,
President

PREPARED STATEMENT OF UNITED WAY OF NEW YORK CITY

United Way of New York City is pleased to have the opportunity to submit testimony on the problems of drug exposed babies.

There is no question that prenatal exposure due to maternal drug use is a critical problem in New York City. Anonymous testing of newborns shows that 11 to 20 percent test positive for illicit drugs. In the most recent full City Fiscal Year, 4,875 babies were reported to the City's Child Welfare Administration because of a positive drug toxicology, up 286 percent from 1986. Our hospitals' infant wards are running at almost 120 percent of capacity, while the nurseries are being deluged with nearly twice the number of children they were designed to accommodate.

The United Way is responding to this need. We support both hospital programs and programs in the community designed to help drug exposed babies. We currently provide funding to many hospital and non-profit programs to help them meet the diverse needs of these children and their families. This includes programs that address the problem of infants suffering from AIDS, because 76 percent of pediatric AIDS cases are attributable to maternal IV drug use. We are pleased to submit testimony to you in conjunction with one of those programs, Project Return Foundation, which will describe some of the problems and solutions in more detail.

In our view, this complex of problems around pediatric drug exposure and AIDS demands a concerted social and medical services response. The programs we help to support provide a range of services, such as placing boarder babies, hastening discharge from foster care, helping drug addicted mothers get treatment and keep their children, caring for babies with AIDS, and finding suitable adoptive homes where necessary.

From our experience with these issues and programs, the main messages we would like to convey to you are:

- The service needs for children and their families created by drugs and AIDS are multi-faceted and long term. There is no simple quick fix. The focus should be on preserving, wherever possible, the family relationship through support services. This means services to deal with the mother's addiction and other problems, the baby's physical and developmental deficits, and their problems as a family unit, such as teaching parenting skills and meeting basic income and housing needs. These supports must be long term to have any hope of success.

- Federal action must be swift and substantial. Our private dollars, though important, can't meet the full service need. United Way funding typically provides core support to strengthen non-profits or funds to explore innovative approaches to problems. Government must provide the bulk of program funding.

- Government's approach should, from the start, incorporate the notion of a partnership with community based non-profit agencies. They are closer to the problem, closer to the client, and connected to the network of community services. They can best implement the multi-faceted response required.

In closing, we would like to inform the subcommittee that United Way of New York City has established eight funding priorities for which we have earmarked a $70 million "priorities pool" for the next five years. These priorities, which in addition to AIDS social services and drug abuse are crime, family violence, illiteracy, homelessness, racial issues, and youth unemployment, form the core of the corrosive force consuming our neighborhoods, families, and citizens. Only by viewing these as interrelated issues can we mount the coordinated response required.

We are making our commitment. We hope it will be just part of a larger one.

PREPARED STATEMENT OF PROJECT RETURN FOUNDATION, INC.

Project Return Foundation is pleased to have the opportunity to submit testimony to Senator Christopher J. Dodd's Children, Family, Drugs and Alcohol Sub-Committee of the Labor and Human Resources Committee, on the problems of drug-exposed babies.

Project Return Foundation, Inc. (PRF), is a non-profit, non-sectarian human services organization. It was founded in 1970 as a self-help program and community center for substance abusers. It has since diversified into other areas of human services and is now the fourth largest therapeutic community in the nation. Through a number of interdependent programs, Project Return Foundation now provides specialized residential treatment services to varied groups, including substance abusers, ex-offenders, the homeless, and a battered women's shelter. These programs admit approximately 1400 men, women and children per year.

Project Return Foundation has a long history of providing services effectively and sensitively to difficult and underserved populations. The expansion and diversification of programs and services have been in response to the changing needs of our constituencies. Project Return Foundation is supported by funds from Federal, State and City governments. It is a participating member of the United Way of New York City.

Project Return Foundation, in this Testimony, will focus on the following issues:

- Who are these drug exposed babies?
- What are the solutions?
- What are the investments for the well-being of future generations?

Who are these drug exposed babies? What are their symptoms?

Each year, more than 300,000 infants are born with traces of some illegal drugs. Close to 5,000 in New York City alone were reported to the N.Y.C Human Resources Administration's Child Welfare Administration with positive drug toxicologies. No one really knows how many are being exposed to drugs, including crack. Generally, these babies are born to women who use a variety of drugs, primary among them, however, are crack and cocaine. Most researchers indicate that the babies themselves are free of drugs not long after birth. However, the consequences from the exposure in utero to these drugs impair the child's normal growth and development.

The range of symptoms of drug dependence and abuse, especially crack and cocaine on newborns reported include hyper-irritability, tremors, gastrointestinal dysfunction, respiratory distress and often, lethargy. In addition, these babies are at risk of low birth weight due to premature delivery. Compounding these are the risks of HIV infection. Current medical knowledge already speaks to developmental delays and potentially more severe disabilities and medical problems for drug exposed infants.

Striking abnormalities have been observed by research groups in babies of mothers who used cocaine during pregnancy. Although the numbers are small and findings inconclusive, many of these babies, now toddlers, are showing symptoms similar to those in children with mild autism and other personality disorders. These are often characterized by withdrawal, lack of attachment to caretakers and lack of emotion. These children may begin life with severe physical and mental problems that are possibly without precedent in contemporary medical, behavioral and social sciences.

Few would argue that these babies deserve the permanence and consistency to promote growth and development. In view of their poor start, these babies will probably require more specialized and intensive attention and care.

Expanding infant care wards and increasing foster care homes and programs, in our view, does not fully address the myriad of needs and other complicating factors that result from being born addicted. We must also consider additional bold strategies which are in contrast to those which separate the family unit.

One which Project Return Foundation is proposing is the examination of the potential of a healthy mother/child relationship. It is not possible for us to look at the needs and problems of drug exposed babies and propose solutions without addressing what has gone wrong with their families, particularly their mothers. We believe that the dangers of fragmentation of families which result in fragmentation of services will exacerbate dysfunction.

Who are their mothers?

These women typically are from single parent families, poor, in ill health living in substandard housing, or homeless. More often they are dependent upon a complex welfare system difficult to cope with, and a health care network with insufficient resources to meet their needs.

Low self-esteem and self-worth are bred by dysfunctional families. It is worsened by school failure, poor employability and homelessness. Drug addiction and emotional illness are symptomatic of these social problems.

As national attention has focused on the problems of drug abuse, particularly among women, and its attendant consequences, "scientists" have begun to delineate subpopulations of substance abusers. One such group to emerge is the mentally ill chemical abuser who exhibits or masks signs of mental disorder. Among the groups of MICA clients, as they are called, at highest risk are women who are the mothers of drug exposed infants and their young children.

According to research conducted under the auspices of Project Return Foundation, mothers who are MICA cannot be construed as either a substance abuser who is mentally ill or as a mentally ill person who is a substance abuser. They present a stubborn challenge to multiple human service systems. The major obstacle is that these systems present barriers to integration of the services they need.

Consider the case of Mary D. who is a 32 year old Hispanic, divorced female with three children. She has a long history of psychiatric treatment centered around episodes of reported suicide attempts and depression. She has used drugs for over ten years, but recently dropped out of a drug rehabilitation facility. She has not been able to take care of her children. A 14 year old daughter was placed in foster care in a residential school for children with behavioral problems when her mother was first hospitalized. A 13 year old daughter has been in foster care placement since birth. The youngest child, a two year old boy, has been cared for by Mary D's sister-in-law whom the boy regards as his only mother. Women presenting these kinds of situations are not rare. In our current women's drug treatment facility, 80% of the clients are indicative of these complicated problems.

What are the solutions? /One Plan of Action

A growing and increasingly complex population of dually diagnosed women and substance involved children demands innovative approaches to service delivery, treatment, diagnosis and research. A belief that this population and their children can be served properly within existing frameworks represents a dubious and failure-prone basis for future work.

Project Return Foundation has developed a program that will focus on the treatment needs of the woman and her drug exposed child. The Women and Children's Treatment Center, now in the implementation stage, after four years of planning and negotiation, will operate an integrated residential, day treatment and continuing care program for dually diagnosed (MICA) women and their young children, up to three years old.

Emphasis will be placed on comprehensive interdisciplinary services for both the women and children. This will include a range of treatment services such as mental health, substance abuse, vocational counseling, parenting skills, child development, with the overall goal of keeping families together whenever possible. Other implicit interdependent goals are to achieve abstinence and effectively manage prescriptive medications to permit women to function optimally.

The facility will occupy a renovated building in East Harlem in New York City for 86 women and children. Living space for 25 women and 25 children will be available in the 24-hour residential center. Children and their mothers will initially be living in close, but separate quarters, representing a "safe house" for each.

Because many of the mothers will be entering treatment in crisis, having been detoxified or discharged from another institution or without shelter, they will require round-the-clock care and supervision.

An important goal will be to help foster a healthy bond between the mother and child during their 9 to 12 month stay at the Center and before joining the continuing treatment program.

Because of the unusual circumstances and special needs associated with this dually diagnosed population, intensive continuing care services will be provided in the same building as the residential program for an additional 18 women and 18 children requiring 24 hour supervision. Many of the direct care staff will provide specific services for both the residential and continuing care programs to ensure continuity of service and provide the necessary reinforcement to women for attaining success.

Individualized treatment services for the children will focus on infant stimulation and toddler training and other childhood development methods to enhance the child's growth. Specialized treatment will be given for infants who exhibit severe symptoms of "failure to thrive." A quality care therapeutic nursery will serve as a discrete entity within the total program. In the nursery, the infant will live in a therapeutic environment with consistent interaction with their own mothers, child specialists, counselors, and other children, under the guidance of a developmental pediatrician.

Of special focus will be activities that strengthen healthy ties between mother and child, including parenting skills training, supervised mother/child interaction time, family counseling and other socializing activities.

What are the investments?

Innovation and change are never easy, particularly when it involves crossing institutional domains as does the Women and Children's Center. Because of the nature of dually diagnosed mothers and their needs, four separate government organizations had to be crossed to obtain support, approvals and funding for the Center: Mental Health, Substance Abuse, Social Services (child welfare) and Housing. Each had its own legislative mandate, priorities, regulations and culture. In addition, each has its own professional ideology and "credentialing" preferences. Under any circumstance, attempting to influence such institutions requires considerable commitment and skill.

Despite these constraints, Project Return Foundation has been successful in obtaining funds from the U.S. Department of Housing and Urban Development (HUD), the New York State Office of Mental Health, the New York State Division of Substance Abuse Services, New York State Department of Social Services and from the New York City Department of Housing Preservation and Development.

Project Return Foundation was awarded the second largest grant in the country from the HUD McKinney Homeless Assistance Transitional Housing Demonstration Program. In addition, the United Way of New York City provided special funding for program planning.

This residential and continuing care program for MICA mothers and their children is a pioneering effort. There are no precedents for working with this dyad, and, at this writing, the first MICA inpatient and outpatient programs for men and women began only three to four years ago.

The cost of treatment for women and their children under this model while substantial is still less than treating both, individually, through the foster care, psychiatric, substance abuse and prison systems.

One caveat must be kept in mind as the program develops. Unknown factors will emerge in the course of working with mentally ill addicted patients and their children. It is more than likely that the syndrome will not add up to the sum of its parts. Therefore, a program designed for MICA's should be flexible, open to continuous research and reassessment. However, given the magnitude of the problem, it is important to move ahead, to explore ways to adapt successful treatment models and strategies from related areas of mental health and substance abuse treatment, to call upon experience and available research in our effort to treat MICA mothers and their high risk children. This problem will affect the health and well-being of these parents and their children into the next generation.

Senator DODD. The subcommittee will stand adjourned until further call of the Chair.

[Whereupon, at 5:55 p.m., the subcommittee was adjourned, subject to the call of the Chair.]

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